PREFACE

The Balanced Budget Act of 1997 directed The Health Care Financing Administration (HCFA) and the Department of Defense (DoD) to conduct a subvention demonstration to test the feasibility of establishing Medicare managed care plans within the DoD TRICARE program for beneficiaries who are eligible for both DoD and Medicare health insurance benefits. These plans, called TRICARE Senior Prime plans, are intended to expand access to military health care services for dually eligible beneficiaries while maintaining budget neutrality. The legislation also authorized military treatment facilities in the demonstration sites to enter into provider contracts with Medicare health plans, called Medicare Partners agreements. Under a Memorandum of Agreement, DoD and the Department of Health and Human Services authorized an independent evaluation of the demonstration to be performed for HCFA and DoD. In September 1998, HCFA awarded RAND the contract to perform this evaluation.

This Interim Report describes the results from our early evaluation efforts. Chapter 1 provides an introduction, Chapter 2 documents our evaluation methods and data, and Chapter 3 describes the policy framework. In Chapter 4, we describe the six demonstration sites and provide data on early enrollment. In Chapter 5, we report the results of our initial round of site visits conducted with all six sites. Chapter 6 provides a preliminary review of the payment methods, and Chapter 7 concludes with some implications for future policy.

Future reports will focus on quantitative evaluation of data from both demonstration and control sites. These efforts will examine the impact of the demonstration on access, utilization, costs, quality, and satisfaction for both the dual eligibles and other populations. They also will document the findings from another round of site visits.

The work presented in this report was performed under Task 6 of Health Care Financing Administration Contract Number HCFA-500-96-0056, Project Officer William J. Sobaski, which is funded by Inter-Agency Agreement HCFA-98-76 with the Office of the Assistant Secretary of Defense (Health Affairs), LTC Thomas V. Williams, DoD Assistant Project Officer.

CONTENTS

FIGURE AND TABLES

Figure

Tables

SUMMARY

The Health Care Financing Administration (HCFA) and the Department of Defense (DoD) are testing the feasibility of making Medicare-covered health care services available to Medicare-eligible DoD beneficiaries in the TRICARE program and military treatment facilities. This is being done through the Medicare-DoD Subvention Demonstration, which was established by the Balanced Budget Act of 1997 (BBA). The goal of the demonstration is to implement cost-effective alternatives for care for this dual-eligible population while ensuring that total federal costs for either HCFA or DoD are not increased. In response to the BBA, the Secretaries of the Department of Health and Human Services and Department of Defense have executed a Memorandum of Agreement (MOA) that specifies how the subvention demonstration will be designed and operated. The MOA provides for an independent evaluation of the demonstration, which is being conducted by RAND.

The demonstration is testing two subvention models in six demonstration sites:

- ***TRICARE Senior Prime*** establishes Medicare+Choice health plans operated by DoD, under contract with HCFA, in the six demonstration sites. Senior Prime enrollees choose a military primary care manager (PCM) at a participating military treatment facility (MTF). They receive their primary care at the MTF, as well as other services the MTF provides. For any services not provided by the MTF, enrollees are referred to other MTFs or to civilian providers under contract in the Senior Prime network, depending on facility proximity and enrollee choice.
- ***Medicare Partners*** provides for formal agreements between Medicare+Choice plans and MTFs in the demonstration sites, under which MTFs would provide specialty and inpatient services for DoD beneficiaries enrolled in the plans. No Medicare Partners agreements have been established thus far, and it remains uncertain whether this model will be implemented.

This Interim Report presents early results from RAND's evaluation of the Medicare-DOD subvention demonstration, and it begins to examine implications for establishing Senior Prime as a permanent part of the TRICARE program. These evaluation results focus on the early implementation activities of TRICARE Senior Prime. The sites have been generally successful in managing the implementation process in quite a compressed start-up period, and in attracting enrollments by military retirees. However, the Senior Prime payment methodology is complex and creates potentially conflicting financial incentives, which may be interfering with achievement of cost-effective operation of the Senior Prime plans. The sites have been in full operation for only 6 to 10 months, depending on the site, so it is too early to assess the effects of Senior Prime on dual-eligible beneficiaries or on government costs.

BACKGROUND

The Current Military Health System

Over a million U.S. military retirees and their elderly dependents are eligible for Medicare health coverage, and they also are eligible to obtain health care services from military

treatment facilities. Under current law, when Medicare beneficiaries obtain health care services at treatment facilities operated by the DoD or Department of Veterans' Affairs (VA), Medicare cannot reimburse either organization for those services. Furthermore, individuals who are eligible for both Medicare benefits and benefits from the DoD, the VA, or both, are free to choose where they will obtain their health care.

In 1995, the Military Health Service developed TRICARE as a new health insurance program to cope with rapid changes in the health care environment, including rising costs, base closures, and shifts in the beneficiary population. TRICARE is a managed care program based on civilian models. TRICARE has established priorities for access to MTF health care, under which Medicare-eligible DoD beneficiaries have the lowest priority (following all active-service military personnel, dependents, and other retirees), and they are provided care on a "space-available" basis. Their access to MTF services has declined as TRICARE Prime enrollees have used increasing shares of MTFs' service capacity. Thus, dual eligibles are obtaining larger portions of their health care in the civilian sector, despite preferences by many of them to use the military health system. Although Medicare-eligible retirees do not have a military option for managed health care, they may enroll in other Medicare health plans serving their local markets.

The Medicare Program

Managed care options have been an official part of Medicare since 1983, and beneficiaries living in areas served by Medicare health plans can elect to join these plans. Medicare plans provide enrollees all standard Medicare-covered benefits, plus some supplemental benefits. The BBA replaced the previous Medicare health plans with the Medicare+Choice program, which allows a variety of managed care organizations to contract as capitated health plans. Contracting plans are paid capitation payments by HCFA, which are county rates adjusted by enrollees' risk factors. Senior Prime plans are certified by HCFA as Medicare+Choice health plans.

THE MEDICARE-DOD SUBVENTION DEMONSTRATION

A relatively long history precedes the establishment of the subvention demonstration by the BBA, starting with exploration by DoD of various options to expand military health benefits for its older beneficiaries. These initiatives have been stimulated, at least partially, by the activities of military retiree associations, which have placed a high priority on improving access to military health care for dual eligible beneficiaries. These groups are seeking DoD action to deliver on the promise that military personnel would be provided health care coverage for life.

Provisions for Senior Priie

The establishment of a mechanism for financial subvention, which is the transfer of funds from HCFA to DoD, creates opposing financial interests for these two government bodies, even as they share commitments to provide access to quality health care for their beneficiaries. Therefore, a challenge for HCFA and DoD in designing the demonstration was to reconcile their fundamental goals. From HCFA's perspective, the Senior Prime program needed to (1) protect the solvency of the Medicare Trust Funds, (2) provide for beneficiary choice and protections, and (3) ensure effective plan performance. From DoD's perspective, the goals were to (1) contribute

to fulfilling the moral obligation to provide DoD beneficiaries with lifelong health care, (2) maintain budget neutrality in the military health system, and (3) strengthen the capability to provide cost-effective managed care in the TRICARE program.

Many of these goals are reflected in the BBA provisions for the demonstration. Key provisions include a requirement that Senior Prime plans be certified as Medicare+Choice plans and several provisions that limit Medicare spending to protect the Trust Funds. As directed by the BBA, DoD and HCFA negotiated a Memorandum of Agreement (MOA) that specifies how they will implement the BBA requirements for Senior Prime and delineates provisions for Medicare Partners. A complex payment methodology was developed that determines capitation payments from HCFA to DoD for services to Senior Prime enrollees. Payment provisions include:

- a methodology to establish the baseline "level of effort" (LOE) spending that DoD must meet before receiving any additional (net) capitation payment from HCFA,
- thresholds for percentages of the LOE (for enrollees or non-enrollees) that determine whether and how much DoD will be paid,
- methods for triggering interim payments to DoD and for determining the amount of the payments, and
- provisions for year-end reconciliation of payments.

Beneficiary participation in Senior Prime is voluntary. Eligible beneficiaries who choose to participate must agree to receive all covered services through Senior Prime. The covered benefits are defined as the "richer of DoD or Medicare benefits." Enrollees have no cost sharing for services provided by MTFs, but they do pay part of the costs for network provider services.

Site Characteristics and Enrollment

Six sites were chosen for the demonstration: Dover AFB in Delaware, Keesler AFB in Biloxi MS, Madigan AMC in Tacoma WA, the Colorado Springs site consisting of two MTFs, the Region 6 site consisting of two MTFs in San Antonio (Brooke AMC, Wilford Hall MC) and two MTFs in the Texoma area on the Texas-Oklahoma border (Reynolds ACH, Sheppard AFB), and the San Diego Naval MC in California. The sites were selected by the DoD, with approval by HCFA, to represent a diversity of characteristics for the participating MTFs and the Medicare managed care markets where they are located.

At each of the sites, three organizations have important roles in operating Senior Prime. The TRICARE regional Lead Agent (LA) Office serves as the official Plan that HCFA holds accountable for plan performance and compliance with Medicare requirements. The sites' LA Offices have assumed a leadership role in bringing together the local participants to manage Senior Prime activities. The second organization is the MTF (or MTFs) that participate as the principal service providers for Senior Prime enrollees. The third organization is the region's Managed Care Support (MCS) contractor, which provides administrative support functions for marketing and enrollment, maintenance of provider networks, quality and utilization management, and claims processing. TMA currently is paying the MCS contractors on a cost-plus basis for Senior Prime functions, reflecting uncertainty early in this program regarding the specific tasks the contractors would be performing and related resource requirements.

The health care markets for the demonstration sites vary considerably (see Table S.l). The larger MTFs tend to be in locations with larger dual-eligible populations and with substantial penetration of Medicare managed care (measured as percentage of total Medicare beneficiaries enrolled in health plans as well as number of health plans). The Dover APB site is unique in that its MTF is a clinic with no inpatient services and limited specialty services. This site is in a rural market with limited Medicare managed care penetration. The San Diego site has the largest dual-eligible population, and its market has the highest managed care penetration. The characteristics of the remaining sites are arrayed between these two sites.

Table S.l
Medicare Managed Care Market Profiles for the Demonstration Sites

	Number of Dual-Eligible Beneficiaries	1999 Medicare Capitation Rate *	Medicare Plan Enrollment Rates (percentage)	Number of Medicare HMOs >1% Share **	Largest HMO Market Share
Dover AFB	3,730	$479	6.1%	1	59.7%
Keesler APB ***	7,601	560	12.3	3	78.5
Madigan AMC	19,565	422	28.2	6	37.2
Central Region	14,346	426	38.6	6	55.8
Region 6					
San Antonio	35,187	472	33.8	4	41.5
Texoma area	7,336	381	4.2	2	70.8
San Diego NMC	36,184	528	49.4	5	62.3

SOURCE: Analysis of January 1999 Medicare market penetration data published 1999 Medicare capitation rates, DoD data on zip codes in MTF catchment areas, zip code/county crosswalk files.

* Average Medicare+Choice base rates for the counties in each catchment area, weighted by number of beneficiaries in each county. These are NOT the base capitation rates for the subvention sites.

** The number of HMOs does not include the Senior Prime plan.

*** The only substantial Medicare health plan enrollment is on the edge of the Keesler service area in Alabama.

Table S.2 reports enrollment figures by demonstration site. As of June 1999, there were 25,627 dual eligibles enrolled in Senior Prime. Enrollment varies considerably by sites, ranging from a low of 705 in Dover to a high of 12,461 in the Region 6 site. Enrollment appears to be leveling off except for the Colorado Springs and San Diego sites, where new enrollments are continuing at a fairly steady pace. All sites, with the exception of Dover, also are gaming new enrollees as TRICARE Prime enrollees age into Medicare eligibility and switch to Senior Prime.

Table S .2
TSP Enrollments and Percentage of Planned Enrollments, as of June 1999

	Demonstration Site(s)						
Month-Year	All	San Diego	Colorado Springs	Dover	Keesler	Region 6	Madigan
June 1999	25,627	3,031 (75.8)	2,995 (88.1%)	705 (47.0%)	2,745 (88.5%)	12,461 (98.1%)	3,690 (111.8%)

SUMMARY OF EARLY EVALUATION FINDINGS

The RAND process evaluation documented and performed preliminary assessments of the following activities involved in the initial phase of Senior Prime implementation:

- obtaining Medicare certification for the Senior Prime plans,
- marketing and enrollment of beneficiaries,
- enrollee intakes and initial service delivery, and
- managing and monitoring Senior Prime plan performance.

The evaluation results offer some preliminary perspectives on the implementation strategies and actions, highlighting areas where successes have been achieved and others where modifications might be made to strengthen the program as the demonstration continues. Our evaluation approach responds to the particular interest by HCFA and DoD to be able to apply lessons from the demonstration to a larger Senior Prime program, should the Congress make the program permanent and remove restrictions on the number of sites.

Process Evaluation Methods

During the process evaluation, we collected information about (1) roles and activities for HCFA and TMA staff from the early negotiations through the implementation of Senior Prime, (2) activities and issues at the demonstration sites as their teams implemented Senior Prime, and (3) impacts of Senior Prime on each of the participants in Senior Prime or other stakeholders. We prepared a master list of questions to guide interviews with participants, from which we developed several specific interview guides for particular groups such as HCFA regional staff or TMA staff (see Appendix A). Using individual and group interview techniques, we interviewed 15 staff in the HCFA central and regional offices and 10 TMA staff involved in both the early negotiations and current implementation activities. We also performed on-site visits to the six sites in January through April 1999, where we conducted group interviews with Senior Prime participants, as well as focus groups with primary care providers, specialty providers, and other front-line staff. (A template for the site visits is in Appendix B.)

The Implementation Process

Working within demanding time deadlines, the participants in the subvention demonstration achieved an impressive accomplishment in getting the TRICARE Senior Prime plans designed, certified, and into operation in less than 6 to 9 months. HCFA and DoD invested innumerable hours of effort completing the terms of the MOA and providing direction to the demonstration sites as they prepared for Medicare certification. The sites were committed to the successful operation of Senior Prime, and they applied their military skills to mobilizing efforts to get it done. The Medicare certification process required substantial investment of staff resources, especially due to the relative absence of in-house knowledge of Medicare regulations and operating requirements. With TMA financial support, the MCS contractors hired private consultants with Medicare expertise to support the sites in their implementation tasks. Senior Prime service delivery appears to have been responsive, and efforts are being made to apply care management techniques to avoid unnecessary care.

Presented in Chapter 5 of this Interim Report are summary descriptions of the roles and responsibilities of TRICARE Management Activity (TMA), the organizational structures and provider networks that the sites established for the Senior Prime plans, and the processes through which the sites enrolled beneficiaries and initiated service delivery. Appendix C contains individual, site visit reports from the six sites with additional documentation. These reports were reviewed by the sites for factual accuracy before being finalized.

Responses of Beneficiaries to Senior Prime

Positive early responses of the beneficiaries, as reported by site staff and representatives of military retiree associations, testify to the apparent success of the Senior Prime plans in delivering services. Although few of the sites reached their planned enrollments immediately, their enrollment rates generally were faster than Medicare enrollments in many private health plans. Beneficiaries who enrolled in Senior Prime have expressed pleasure regarding their early experiences with the plan and the services they are receiving. Those who chose not to enroll had valid reasons for their decisions, perhaps the most significant one being the short two-year life of the demonstration.

Cost Incentives and Implications

One of the difficult issues emerging from the early phase of the demonstration is the inadequacy of the financial provisions. Two basic problems may be discouraging the sites from managing the cost side of their operations along with the clinical side: (1) the complexity of the payment methods, which makes it difficult for the site staff to understand the effects of payments on their operations, and (2) uncertainty over whether the sites will ever see Senior Prime revenues, even if DoD obtains net payments from HCFA after each year's reconciliation. Until these issues are resolved, it may be difficult for DoD to achieve budget neutrality for Senior Prime. To the extent that negative financial performance has a detrimental effect for beneficiaries, the basic aims of both HCFA and DoD to serve their beneficiaries may be compromised.

IMPLICATIONS FOR A BROADER SENIOR PRIMECARE PROGRAM

The early demonstration experiences highlight several factors that need to be considered when designing such a program, and they point to ways to strengthen program implementation.

Policy Issues for Program Design

If the Congress passes legislation making Senior Prime a permanent part of TRICARE systemwide, some of the program features may need to be strengthened, building upon lessons from the demonstration, and other features may require modification because they do not generalize well to a larger scale program. We have identified several policy and design issues that HCFA and DoD would need to address in designing a larger Senior Prime program.

Balancing interactions between the readiness mission and Senior Prime. Three aspects of the readiness mission are pertinent to Senior Prime: recruitment and retention of

medical personnel, maintenance of clinical skills for readiness sustainment, and medical personnel deployments. Although the sites generally report that serving the older population in Senior Prime contributes to the first two aspects of readiness, there is real tension between deployment demands and ensuring continued services to Senior Prime enrollees. Entering into a Senior Prime contract with HCFA creates an obligation to provide enrollees needed health services. When deployments remove medical resources from MTFs, contingency plans are needed to ensure that services to enrollees are not unduly interrupted. It also is not yet clear how much similarity there is in the mix of clinical skills required for readiness and for serving an older population.

Structuring and managing Senior Prime effectively. The configurations chosen for Senior Prime plans for a larger system, and the mix of MTFs that participate in them, will define the system's profile of enrollees, service delivery, and financial performance. The early results of our process evaluation indicate that medical centers or community hospitals with a balanced mix of primary care and specialty care were able to move into Senior Prime most easily and quickly. Larger medical centers may have more trouble gearing up for Senior Prime than other facilities, unless they already have experience with PCM care management under TRICARE Prime, although their depth of clinical specialty capability enables them to serve most health care needs for enrollees. (This capability is a benefit, however, only if the medical center costs are lower than the prices paid to network providers).

Creating the desired financial incentives. The sites have expressed dissatisfaction with many aspects of the payment formula, and they are frustrated by the absence of cash flow to help cover the costs of care the MTFs are providing to Senior Prime enrollees. Such an uncertain financial environment may discourage active management of costs of care, if MTFs believe that their actions have little influence on their financial outcomes and rewards or penalties for performance. Given this, it would be appropriate to re-evaluate the payment system for Senior Prime to seek a design that can (1) reduce uncertainties for the sites regarding their potential financial performance and the consequences for them and (2) align the sites' incentives so they can focus on providing quality care to enrollees and managing the costs to do so. Any modifications to payment methods should be guided by the financial principles laid out by HCFA and DoD to protect the Medicare trust fund and maintain budget neutrality for the DoD.

Achieving effective clinical and cost performance. Both short-term and long-term challenges exist in this area. In the short term (for the remainder of the demonstration), the sites face the challenge to manage care proactively to ensure that MTFs are providing Senior Prime enrollees appropriate and efficient (i.e., cost effective) care. In the longer term, to prepare for a systemwide program, the DoD should continue its efforts to establish consistent practice standards that all MTFs may use, and it should explore ways to provide for greater UM flexibility into MCS contracts. DoD data system capabilities need to be built to generate timely and actionable information for the MTFs' QMAJM activities and for DoD use to monitor the cost effectiveness of care in its facilities. Careful assessment also is merited for two distinct aspects of administrative costs incurred during the demonstration: the reportedly heavy resource investment made by TMA and the sites to make Senior Prime operational, and costs incurred by MCS contractors to support the program.

Demonstration Lessons for Effective Implementation

Several lessons for improving Senior Prime implementation emerged from our site observations, which are summarized in Chapter 7 of the report. These lessons pertain to the enrollment and start-up of service delivery, and to ongoing operation of Senior Prime services. Issues related to achieving adequate program support from data systems operated by DoD and other organizations also were identified.

Enrollment and startup of service delivery. Lessons and possible strategies addressed in this area include preparation for enrollment activities, careful definition of enrollment targets, planning and execution of marketing strategies, processing of enrollment applications, use of staged enrollment, preparation of physicians and other staff to participate in the program, and provisions to avoid interruptions in care for new enrollees with existing health problems.

Early operation. Although the sites have been in full operation for only a limited time, several items have arisen regarding service efficiency and responsiveness that merit continued attention during the demonstration. These include the desirability of methods to improve the efficiency of Medicare compliance activities, techniques to enhance PCM physician productivity in serving Senior Prime enrollees, dislike by enrollees of automated appointment systems, and the need to monitor changes in activity for ancillary services with the introduction of Senior Prime.

Data system capabilities. To perform effectively in Senior Prime (or in other aspects of TRICARE services), the sites require complete, accurate and timely data to support local clinical teams as they monitor and manage service utilization and provider performance. Although DoD is making progress in strengthening its data systems, the sites express frustration that they still are not able to obtain the data they need from these systems. As a result, they are turning for data to their own local systems (e.g., CHCS, ADS), which makes it difficult to compare quality or utilization metrics across sites. Sites also are working on improving the completion of ADS bubble sheets for outpatient visits, and some are training providers on proper coding techniques for diagnosis and procedure codes. In a larger Senior Prime program, it will be especially important to streamline the enrollment processing system, which currently requires MCS contractor staff to work with as many as 4 non-integrated data systems-

ACKNOWLEDGEMENTS

We are pleased to acknowledge the contributions of the many people with whom we have interacted during our work thus far on the evaluation of the Medicare-DOD subvention demonstration- We thank the Senior Prime participants at the six demonstration sites whom we interviewed during our initial round of site visits for their careful planning for our visits and their candid discussions of activities during the program's start-up period. We are especially grateful to our points of contact in the Lead Agents' Offices, whose responsiveness and organizational skills helped make our visits so productive. As a result, we gained a richer understanding of Senior Prime as well as many valuable insights into issues involved in its planning and implementation. Numerous other individuals in the HCFA central and regional offices, and in the TRICARE Management Activity also shared valuable time with us to offer their perspectives on the history of the subvention demonstration and their experiences as Senior Prime was being implemented. This diversity in both information and viewpoints yielded valuable information for the process evaluation.

Thanks also go to the many individuals who reviewed the draft of this Interim Report, whose comments helped to strengthen and clarify its presentation. We thank our RAND colleague, Susan Hosek, for her very thoughtful consideration of the policy issues in the context of her familiarity with the Military Health System. We also appreciate the helpful comments on policy, technical, and presentation aspects of the draft report provided by the members of our Technical Advisory Panel: John Moxley, Joseph Newhouse, and Richard Southby.

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The administrative and organizational support provided to this project by Diane Schoeff has been essential to our ability to schedule and perforrn the evaluation site visits, obtain data required for the evaluation, produce report documents, and numerous other tasks. We also would like to thank David Adamson for drafting the Executive Summary for this report and Deborah Rivera for preparing the final manuscript.

ACRONYMS

ACH	Army community hospital
ACR	Adjusted Community Rate
ADPL	average daily patient load
ADS	Ambulatory Data System
AFB	Air Force base
AF	Air Force
AMC	Army medical center
BBA	Balanced Budget Act of 1997
BRAC	Base Realignment And Closure
BSR	Beneficiary Service Representative
CDR	Commander
CEIS	Corporate Executive Information System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CHIC	Current Health Insurance Claim number (Medicare)
CMAC	CHAMPUS Maximum Allowable Charge
CRIS	CHAMPUS Regional Intermediary System
CSH	combat support hospital
DEERS	Defense Eligibility Enrollment Reporting System
DHHS	Department of Health and Human Services, U.S.
DME	durable medical equipment
DMIS	Defense Medical Information System
DoD	Department of Defense
DRG	Diagnostic Related Group
EBC	enrollment-based capitation
EDB	Enrollment data base (HCFA)
EAPP	Enrollment Application
EEHAS	Enrollee Education and Health Assessment Strategy
ESRD	end stage renal disease
FEHBP	Federal Employees Health Benefits Program
FFS	fee for service
FHFS	Foundation Health Federal Services, Inc.
FORSCOM	Forces Command
FY	fiscal year
GAO	General Accounting Office
GHP	group health plan
GME	graduate medical education
HCFA	Health Care Financing Administration
HCSR	Health Care Service Records
HHS	Health and Human Services, U.S. Department of
HMO	health maintenance organization
ICU	intensive care unit
LA	Lead Agent
LOE	level of effort
LOS	length of stay
MC	medical center
MCFAS	Managed Care Forecasting and Analysis System

MCP	managed care program
MCS	managed care support
MCSC	managed care support contractor
MDC	major diagnostic categories
MEDPAR	Medicare Provider Analysis Review
MEPRS	Medical Expense and Performance Reporting System
MEQS	MEPRS Executive Query System
MHS	Military Health System
MOA	Memorandum of Agreement
MPC	Medicare Processing Center
MTF	military/medical treatment facility
MTW	major theater war
M+C	Medicare+Choice
N-MC	Navy medical center
OMB	Office of Management and Budget
OSHPD	Office of Statewide Health Planning and Development
PCM	primary care manager
PGBA	Palmetto Government Benefits Administrators
PLCA	Patient Level Cost Allocation
PMO	Program Management Office (CEIS)
POC	point of contact
PPS	Prospective Payment System
PRO	professional review organization
PROFIS	Professional Filler System
PRPWG	Population and Resource Projection Working Group
PWP	Professional Weighted Product
QA	quality assurance
QISMC	Quality Improvement System for Managed Care
QM	quality management
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SIDR	Standard Inpatient Data Record
SNF	skilled nursing facility
SSN	Social Security number
TEFRA	Tax Equity and Fiscal Responsibility Act
TMA	TRICARE Management Activity
TSP	TRICARE Senior Prime
UM	utilization management
USAF	U.S. Air Force
VA	Veterans Affairs, Department of
VRI	Vector Research, Inc.
VTC	video-telephone conference
WPS	Wisconsin Physicians Service
Y2K	Year 2000

Chapter 1

INTRODUCTION

The Health Care Financing Administration (HCFA) and Department of Defense (DoD) are implementing the Medicare-DOD Subvention Demonstration to test the feasibility of making Medicare-covered health care services available to Medicare-eligible DoD beneficiaries through the TRICARE program and military treatment facilities. The goal of the demonstration is to "implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either HCFA or DoD."[1] The demonstration is being undertaken in six sites in response to direction by the Balanced Budget Act of 1997 (BBA).

The Secretaries of DHHS and DoD have executed a Memorandum of Agreement (MOA) that specifies how they will establish and operate the Medicare Subvention Demonstration, subject to BBA provisions. Two mechanisms are to be implemented. The first is a new Medicare managed care plan option—TRICARE Senior Prime-through which DoD, under contract with HCFA, operates Senior Prime plans at the six demonstration sites as Medicare health plans. Senior Prime plans are administered under both Medicare and TRICARE rules and regulations, although wherever possible, they build upon the infrastructure of the TRICARE Prime program that is the managed care option for military beneficiaries under age 65. The second mechanism is Medicare Partners, an arrangement through which Medicare+Choice organizations can contract with military treatment facilities (MTFs) in the demonstration sites to serve as providers for dual-eligibles enrolled in the plans. No Medicare Partners agreements have been established as of the date of this report.

In September 1998, HCFA awarded a contract to RAND to perform an evaluation of the demonstration. This Interim Report contains the early results of this evaluation; iincluding results of the first round of the process evaluation, analysis of enrollment demand, and preliminary methodological studies for the cost analysis.

THE MILITARY HEALTH SYSTEM

The peacetime military health strategy of the DoD is to provide comprehensive, cost-effective care to active duty members, their families and other eligible beneficiaries in all the Uniformed Services. Much of this health care is provided directly through several hundred military hospitals and clinics that constitute the system of military treatment facilities. MTFs provide care to all military beneficiaries free of charge as capacity permits. Each MTF has a defined service area called a catchment area, which generally includes the zip code areas within a

[1] From the Memorandum of Agreement for conduct of the demonstration that was executed by the Department of Health and Human Services and the Department of Defense.

40 mile radius of the MTF. Although most military beneficiaries live within such a catchment area, less than half of the older, Medicare-eligible beneficiaries are in catchment areas.[2]

The Military Health System (MHS) currently provides health care to approximately 8.2 million beneficiaries. In FY97, elderly military beneficiaries (those age 65 or older) represented an estimated 15.5 percent of the total MHS beneficiary population. Younger retirees and their dependents were. an additional 24.5 percent of the total FY97 beneficiary population, and the elderly retiree population will increase as these military beneficiaries age into Medicare-eligibility.

The DoD health service mission has been challenged by the rapid rise in health care costs, closures of military bases and their medical facilities, and shifts in the beneficiary population. For instance, as a result of Base Realignment and Closure (BRAC) actions, 35 percent of MTFs providing services in 1987 had closed by the end of 1997. During the same time period, the number of people eligible for care in the MHS decreased by only 9 percent. As the number of active duty personnel and dependents decreased, there was growth in numbers of retired members and their families.[3] The reduction in number of MTFs has curtailed access to military health care for retirees living in areas affected by BRAC actions.

The TRICARE health insurance program, which began operation in 1995, was developed as the DoD response to the challenges facing the MHS. Each of the 11 TRICARE service regions in the United States, Europe, the Pacific, and Latin America is managed by the military in partnership with civilian managed care support (MCS) contractors. A senior military health care officer is designated as the TRICARE Lead Agent (LA) for each region, and the Lead Agent's office is responsible for coordinating the delivery of health care to eligible beneficiaries living in that region. Day-to-day service delivery and clinical decision-making is done by the primary care managers (PCMs) in the MTFs, with oversight by local MTF commanders. The TRICARE Management Activity (TMA) contracts directly with a MCS contractor for each region to provide support services for the region's LA Office. Thus the terms of the MCS contracts are established between TMA and the contractors, in consultation with the LA Offices.

The TRICARE system aims to offer expanded access to care, a choice of health care options, consistent high quality health care benefits, and reduced health care costs for beneficiaries and taxpayers alike. TRICARE is a managed care program modeled after civilian standards. The program offers beneficiaries three choices for their health care: TRICARE Standard, a fee-for-service option that replaced CHAMPUS; TRICARE Extra, a preferred provider option; and TRICARE Prime, an HMO model option. MTFs are the principal sources of health care for TRICARE Prime enrollees, and their services are supplemented by civilian network providers. All active duty members and their families, retirees and their families, and survivors who are not eligible for Medicare may participate in one of the three TRICARE options. Additionally, those individuals under age 65 who are eligible for Medicare because of

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2 Testimony of the Military Coalition on Health Care Concerns of the Uniformed Services Community provided to the Senate Appropriations Committee, Subcommittee on Defense, May 11, 1998.

3 Testimony by Dr. Edward Martin before the Subcommittee on Military Personnel, House National Security Committee, February 26, 1998.

disability or end-stage renal disease (ESRD) may participate. Medicare beneficiaries who are age 65 and over and otherwise eligible for military benefits may not enroll in TRICARE Prime.

Under TRICARE, access for MTF services is offered to beneficiaries in the following order of priority: (1) active duty service members, who are enrolled in TRICARE Prime automatically; (2) family members of active duty service members enrolled in Prime; (3) retirees, their family members and survivors enrolled in Prime; (4) family members of active duty service members who are not enrolled in Prime; and (5) all other beneficiaries. Because Medicare-eligible beneficiaries are excluded from TRICARE, they are in the lowest priority group.

All beneficiaries not enrolled in TRICARE Prime, including Medicare-eligibles, have access to MTF services only if space is available after the MTF serves its Prime enrollees (called space-available care). A combination of an MTF's service capacity limits (usually clinic staffing levels) and the volume of services provided to Prime enrollees determines the amount of space-available care an MTF can provide. As Prime enrollment has grown and budgets have not, space available care has tended to decline, although at varying rates across MTFs.

MEDICARE MANAGED CARE

Managed care options have been an official part of the Medicare program since 1983, when the Tax Equity and Fiscal Responsibility Act (TEFRA) established provisions for risk and cost contracting HMOs. Medicare beneficiaries living in areas served by Medicare HMOs could elect to join one of these plans, and they also could disenroll from a plan at the end of any month. HMOs could participate as either a risk contractor-by far the most common type-a cost contractor, or a health care prepayment plan. Managed care plans have grown' rapidly in recent years-as of December 1998, 6.1 million Medicare beneficiaries were enrolled in 346 risk contracting plans, accounting for 16 percent of the total Medicare population. This represents more than a 16 percent increase in risk plan enrollment since December 1997.

The Balanced Budget Act of 1997 (BBA) replaced the existing Medicare managed care program with the Medicare+Choice program established under a new Medicare Part C. As of January 1999, a variety of managed care organizations are authorized to contract as capitated Medicare+Choice organizations. Existing risk plans may convert to the new program, and the two cost-based options are discontinued (with few exceptions such as union-based plans). The BBA used the TEFRA risk contracting program as a template for the Medicare+Choice program, including a number of beneficiary protections, conditions for participation for contracting plans, and Adjusted Community Rate (ACR) requirements intended to limit windfall profits for health plans in areas with high capitation rates!

The BBA also adopted a new methodology for establishing capitation rates, which went into effect in 1998. HCFA calculates a health plan's capitation payments each month as the sum of the product of the capitation rate for each enrollee's county of residence and the enrollee's risk

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[4] Adjusted community rates (ACR) are rates that plans estimate they would have received for their Medicare enrollees if they had been paid at levels of their private market premiums, adjusted for demographic differences. Each year, plans are required to return to enrollees any excess of Medicare revenue in excess of their ACRs by reducing premiums or increasing benefits for the following year.

factor. The BBA requires development of an improved risk adjustment method, to be implemented in January 2000.

THE MEDICARE SUBVENTION DEMONSTRATION

The impetus for a Medicare-DOD subvention mechanism, whether as a demonstration or as a permanent part of the Medicare and DoD health insurance programs, is rooted in federal statute. Under current law, when Medicare beneficiaries obtain health care services at treatment facilities operated by the DoD or Department of Veterans' Affairs (VA), Medicare cannot reimburse either organization for those services. [5] Furthermore, individuals who are eligible for both Medicare benefits and benefits from the DoD, the VA, or both, are free to choose where they will obtain their health care. As a result, the health care costs of dually (or triply) eligible beneficiaries have been shared by Medicare, DoD and VA according to the mix of service sectors that beneficiaries have chosen to use. Yet because Medicare-eligible DoD beneficiaries are space-available patients for MTFs, their access to services by DoD treatment facilities has been squeezed out as TRICARE Prime enrollees have used increasing shares of MTFs' service capacity. Although these older beneficiaries do not have a military managed health care option, they may enroll in other Medicare health plans serving their local markets.

Two Subvention Models Being Tested

The subvention demonstration tests two distinct models that allow DoD to receive payments for expanded services to Medicare-eligible DoD beneficiaries. The first model, TRICARE Senior Prime, establishes Medicare managed care plans operated by the DoD, in which participating MTFs are the principal health care providers for enrolled beneficiaries. The Senior Prime plans are certified by HCFA as Medicare health plans, and they are subject to the same performance standards as all other Medicare plans, with some exceptions where requirements are waived because of the unique circumstances of military health care. (Refer to Chapter 5 for details on waivers of the Medicare performance standards for Senior Prime.)

The second model, Medicare Partners, allows local Medicare health plans serving the demonstration sites to contract with MTFs to be providers in the plans' networks. According to the BBA, thesecontracts will be for MTF specialty and inpatient services provided to DoD beneficiaries enrolled in the Medicare plans. HCFA performs the same oversight for these contracts as for other provider contracts executed by Medicare health plans. To use MTF services under a Medicare Partners agreement, enrollees of a Medicare health plan must be eligible to receive care from the DoD, be residents of the demonstration sites' catchment areas, and used an MTF prior to January 1, 1998 or became dual-eligible after December 3 1, 1997. The MOA stipulates that DoD will not initiate any Medicare Partners activities in a demonstration site until at least 90 days after the site's Senior Prime plan has started service delivery. No Medicare Partners activity has been undertaken by DoD at this time.

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[5] Section 18 14(c) of the Social Security Act.

Provisions for TRICARE Senior Prime

The barriers to military health care are removed for Medicare-eligible DoD beneficiaries who enroll in a TRICARE Senior Prime plan. Senior Prime enrollees choose a military primary care manager (PCM) at a participating MTF and they receive their primary care at the MTF, as well as all other covered services that the MTF provides. For services the MTF does not provide, enrollees are referred to civilian providers in the Senior Prime network.

TMA established national Senior Prime benefits and cost sharing provisions that apply for all sites.:' By law, the minimum benefits required to be covered were the Medicare-covered benefits, and the MOA gave DoD discretion to expand coverage. The covered services are defined as "the richer of TRICARE benefits or the standard Medicare benefits," and they include some Medicare-specific post-hospital care, such as limited skilled nursing facility (Senior Prime covers up to 100 days of care) or home health visits, as well as other TRICARE Prime benefits (e.g., pharmaceuticals) not covered by Medicare. Senior Prime enrollees do not have to pay any copayments or coinsurance for services provided in the MTFs, but they do have to pay part of the costs for network provider services. Copayments for network provider outpatient services range from $12 to $30 per unit of service, and for acute inpatient services, there is a copayment of $11 per day with a minimum of $25 per admission. Enrollees also pay $40 per day for partial hospitalization or inpatient mental health or substance abuse services by network providers. For ostomy supplies, prosthetic devices, therapeutic shoes, and durable medical equipment @ME), the cost sharing is 20 percent of the negotiated fee.

Beneficiary participation in Senior Prime is voluntary and does not involve any premium. To be eligible, beneficiaries must be age 65 or older, eligible for Medicare Part A and enrolled in Medicare Part B, be residents of a demonstration site's service area, and have used the MTF services prior to January 1, 1998 or became dually eligible for TRICARE and Medicare Part B after December 31, 1997. In addition, enrollees must agree to receive all of their covered services through Senior Prime. DoD beneficiaries who are Medicare-eligible due to end-stage renal disease (ESRD) or who are younger than 65 and Medicare-eligible due to 'disability are excluded from the demonstration. These beneficiaries still may receive care from MTFs on a space-available basis, and those younger than age 65 may join TRICARE Prime.

The capitation payment rates for Senior Prime enrollees are based on the Medicare capitation rates for the counties in which the enrollees reside. The Senior Prime capitation rates are set at 95 percent of these county rates, after deducting the cost of direct and indirect medical education, disproportionate share payments, and a portion of hospital capital payments.[6] In addition, Medicare will pay for enrollees' care only after the DoD has spent as much for health care services to dual-eligibles in the demonstration sites (enrollees and non-enrollees) as it spent in the past, which is called the level of effort (LOE). The MOA defines the baseline LOE as the FY96 DoD expenditures for dual-eligible beneficiaries at each site. The LOE is kept constant for

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[6] For clarity, we note that the county capitation rates are grounded in the historical AAPCCs, which were set at 95 percent of the average per capita costs for Medicare fee-for-service beneficiaries; thus the Senior Prime rate is discounted to 95 percent of the "95 percent Medicare capitation rates."

the duration of the demonstration, except if overall defense health spending changes substantially or BRAC actions reduce DoD's ability to serve dual-eligibles.

The MOA also establishes expense thresholds for Senior Prime enrollees and non-enrollees that are used to determine whether HCFA will make payments to DoD and the levels of those payments. The thresholds were set originally at 30 percent of LOE for enrollee expenses and 70 percent for non-enrollee expenses in the first year of the demonstration, which moved to a 40/60 split in the second year and a 50/50 split in the last year. Because the demonstration will operate for, only two years, an MOA clarification applied these thresholds to shorter time periods: a 10-month period from September 1998 to June 1999, followed by a g-month period through March 2000 and another g-month period through December 2000.

Given these basic payment method elements, net payments to DoD for Senior Prime are calculated each year according to the following rules:

1. If total expenses for enrollees and non-enrollees exceeds the LOE -&--the expenses for enrollees exceed relevant threshold (30/40/50), then DoD will receive payment from HCFA (also expressed as DoD keeping interim payments already made by HCFA).
2. The allowed cost for non-enrollees is the minimum of the actual cost or the relevant threshold (70/60/50).
3. The net payment made to DoD =

   gross capitation payments + allowed cost for non-enrollees - baseline LOE.

Based on these payment rules, net return (or cost) for Senior Prime can be estimated as the net payment made to DoD minus any expenses ***in excess*** of *LOE* that were incurred by the sites for serving dual-eligible beneficiaries.

The BBA authorized HCFA to make interim payments to DoD, and it established annual limits on Medicare spending for Senior Prime enrollees. The MOA defines thresholds to trigger interim payments, methods to determine these payments, provisions for retrospective risk adjustment of payments, and methods for annual reconciliations of payment amounts.

The MOA also specifies how Medicare Partners is to be implemented, stating that: (1) no costs associated with Medicare Partners are counted toward LOE, (2) DoD cannot retain Medicare Partners payments unless the LOE is exceeded, and (3) no more than half of the spending cap each year is available for Medicare Partners.

DoD and HCFA selected the six demonstration sites that include 10 MTFs operated by the Army, Air Force, and Navy, which are listed in Table 1.1. The total planned enrollment for the six Senior Prime plans is 27,800 Medicare-eligible DoD beneficiaries. The sites identified these enrollment levels using a variety of techniques, some of which are targeted enrollments based on market analyses and others are more measures of MTF treatment capacity than expected enrollments.[7] The sites began enrollments soon after they met all the requirements for certification by HCFA as Medicare health plans. Early rates of enrollments have varied across

[7] Examples are the Region 6 site that set enrollment targets based on expected market penetration as well as MTF capacities, and the Dover site that views its level as its maximum MTF capacity - not a "target."

sites, and some - but not all - of the sites have achieved their planned enrollments. (Refer to Chapter 4 for characteristics of the sites and markets and our analysis of enrollment patterns.)

Table 1.1
Subvention Demonstration Sites and Planned Enrollment Levels

Demonstration Site	TRICARE Region	Start Service Delivery	Planned Enrollment
Colorado Springs site:	8		
Evans ACH, Ft. Carson, CO		January 1999	2,000
Air Force Academy		January 1999	1,200
Dover Air Force Base	1	January 1999	1,500
Keesler AFB Medical Center	4	December 1998	3,100
Madigan Army MC/Region 11	11	September 1998	3,300
Southwest Region (Region 6) site:	6		
Brooke Army Medical Center		October 1998	5,000
Wilford Hall Medical Center (AF)		October 1998	5,000
Reynolds ACH, Et. Sill, OK		December 1998	1,400
Sheppard AFB Hospital		December 1998	1,300
San Diego Naval Medical Center	9	November 1998	4,000

THE RAND EVALUATION

The MOA for the demonstration begins with a goal statement that is the driving force for the evaluation being performed by RAND for HCFA and DoD:

> "The goal of this demonstration is, through a joint effort by DHHS and DoD, to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency."

With this goal as the starting point, Attachment E to the MOA specifies questions in four areas that define the scope of the evaluation: benefits for enrollees, cost of program, impact on other DoD and Medicare beneficiaries, and enrollment demand. Within each area, the evaluation is to assess whether the demonstration succeeded and it is to analyze details of program dynamics. HCFA and DoD also have emphasized the importance of obtaining information and tools from the demonstration to enhance their ability to expand Senior Prime plans and Medicare Partners agreements effectively across the military health system, should such a decision be made. Working with these specifications, we designed our evaluation to include:*

- a process evaluation of implementation activities

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[8] Refer to RAND document PM-924-HCFA, entitled "Evaluation Plan for the Medicare-DOD Subvention Demonstration, authored by Donna 0. Farley, Dana P. Goldman, Grace M. Carter, and Lois M. Davis (NTIS accession number PB-99-149056).

- analyses of enrollment demand and disenrollments
- effects of the demonstration on beneficiaries and
- effects on government costs.

The process evaluation gathers and analyzes information on the implementation activities of demonstration participants. Sites' experiences with Senior Prime and Medicare Partners are documented, and operational successes and challenges in program implementation are identified. Implications for a permanent, systemwide program are assessed. This qualitative information also guides interpretation of findings from our quantitative outcome analyses.

This evaluation is one of two independent evaluations of the subvention demonstration. In creating the demonstration, the BBA directed the Inspector General to perform an evaluation, which is being carried out by the General Accounting, Office (GAO). The parties involved in the two evaluations are communicating regularly, and the GAO and RAND coordinated schedules for their respective process evaluations. Although both of the evaluations are addressing the same central issues of the processes and outcomes of implementing the demonstration, they differ in the emphasis they place on certain topics. Therefore, the combined findings of these evaluations should yield richer information and perspectives than those of one evaluation alone.

SCOPE OF THE INTERIM REPORT

Proposals to make subvention permanent were placed before Congress in this session with the filing in April of H.R. 1413 in the House and S. 915 in the Senate. These essentially matching bills would expand the number of sites to 16 effective January 2001 and would repeal the limitation on the number of sites effective January 2002.[9] Whether or not legislation is passed this year, these bills highlight the need to document lessons from the demonstration and evaluate how this information can be applied to the design of a permanent program. It is important to examine the sites' experiences in the context of the policy framework established by the Congress, HCFA, and DoD. The BBA and HHS/DoD MOA define policiesand methods that may function on the scale of the demonstration. Yet some of these provisions may not adapt effectively to a larger Senior Prime program, and modifications to HCFA or DoD policies may be appropriate.,

This Interim Report contains early results from RAND's evaluation, focusing on the early experiences with program design, enrollment, and initial service delivery for the TRICARE Senior Prime plans in the six demonstration sites. Implications for a larger system are considered. Emphasis is placed on Senior Prime because no Medicare Partners activity has occurred yet.

We describe in Chapter 2 the methods used in the evaluation work reported here. The policy framework for the subvention demonstration is examined in Chapter 3, focusing on the principles and aims of HCFA and DoD as they negotiated provisions that guide subvention

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[9] The bills also would establish Medigap protection for disenrollees that is available to other Medicare+Choice plan enrollees, and they would permit HCFA to pay DoD on a fee-for-service basis at rates that do not exceed the rate of payment that otherwise would be made.

activities. In Chapter 4, we describe the sites, their local markets, and their enrollment patterns through June 1999. Building upon this factual foundation, Chapter 5 presents results of our process evaluation regarding the experiences of HCFA, TMA, and the demonstration sites in implementing TRICARE Senior Prime. In preparation for the next steps of our evaluation – examination of the demonstration's impacts on beneficiaries, utilization, and government costs – we present in Chapter 6 some preliminary findings from our analysis of the estimated costs of care by DRG which is a component of the Patient Level Cost Allocation. Finally, Chapter 7 discusses some of the issues that decision makers will face if TFUCARE Senior Prime becomes a permanent program, along with lessons learned thus far from the demonstration to help build a stronger program. We also offer, at the end of this chapter, a preliminary discussion of the prospects for Medicare Partners and related policy issues.

Chapter 2

EVALUATION METHODS AND DATA

The results of three distinct evaluation activities are presented in this Interim Report: the first phase of the process evaluation to assess sites' experiences in implementing the subvention demonstration, analysis of data on Senior Prime enrollment activities, and preliminary testing of some of the unit cost assumptions used to calculate the baseline LOE -- preparing for RAND's analysis of the cost impacts of the demonstration. In this chapter, we describe the methods used for each analysis.

PROCESS EVALUATION

The process evaluation of the Medicare-DOD subvention is designed to:

- Document the activities and experiences of HCFA, DoD, the demonstration sites, beneficiaries, and other stakeholders as TRICARE Senior Prime and Medicare Partners are implemented;
- Generate qualitative information to help interpret the findings of quantitative analyses of the demonstration's effects on utilization patterns, access and quality, and costs; and
- Evaluate the implications of the documented experiences of stakeholders for broader implementation of Senior Prime or Medicare Partners across the military health system.

The planned schedule for the entire process evaluation of the demonstration is presented in Table 2.1. The process evaluation consists of a combination of individual interviews with key staff at HCFA and DoD and on-site visits to the six demonstration sites, as well as interviews or focus groups with other stakeholders in the demonstration. Baseline HCFA and DoD interviews were conducted in March through June 1999, and additional interviews are planned on a semi-annual basis. Two rounds of on-site visits to the demonstration sites are scheduled. The first round of visits, which was conducted in January through April 1999, focused on documenting the strategies and early experiences of the sites as they initiated the Senior Prime program. The second round, which will be conducted in late 2000 at the end of the demonstration, will document the status and activities of the sites after they have time to establish routine procedures and learn from their earlier experiences. In the interim, information will continue to be collected periodically from the sites and other stakeholders using formal videoconference (VTC) or telephone interviews and brief quarterly reports. This on-going information collection will focus on the key policy issues or events for which we want to document changes over time, many of which were identified in the first site visits and are reported in this report.

Table 2.1
Planned Process Evaluation Approach and Schedule

Methods	Schedule
Individual interviews with HCFA, DoD staff	Baseline, semi-annual
Site visit interviews with: • lead agents • MTF command staff • MCS contractor personnel • physician managers • clinical and business managers • military retiree organizations	First site visit at startup (January-April 1999)
Focus groups with "front line" staff, physicians	
Medicare health plan leaders	First year; last year
Focus groups with dual eligibles at all sites	Dual eligibles-2nd visit (Sept-December 2000)
Middemonstration update on site strategies using telephone interviews with site leaders, DoD, HCFA, LAs	End of 1999
Beneficiary feedback documented in MTF records for enrollments, complaints, grievances, others to be explored with sites	Quarterly
Site progress reports by telephone-check list of questions	Quarterly
Document MTF organization and operation from sites' written materials	As needed

We present here our data collection methods for the first round of interviews and site visits, including the types of baseline information we sought and the interview or focus group techniques used to collect that information. Then we describe the interviews conducted with HCFA and DoD staff and the structure and processes used for the site visits.

Data Collection Methods

The methods used to collect data for the demonstration activities of interest to the evaluation are listed in Table 2.2. Standard formats and procedures were used for data collection to ensure consistency across interviewers, sites, and time periods. To enhance our ability to capture the diversity of perspectives on implementation issues, we addressed many of the questions with several different stakeholders.

Table 2.2
Process Evaluation Data Collection Methods

	Personal Interviews	Croup Discussions	Provider Focus Groups	Retiree Assn. Leaders
Overall strategies	X	X		
Initial views on demo	X	X	X	X
Execution of MOA	X	X		
Flow of funds	X	X		
Organization of system	X	X		
Meet HCFA requirements	X	X	X	
Training and education	X	X	X	
Provider networks	X	X	X	
Enrollment and marketing	X	X		
Quality assurance	X	X	X	
Actions and experience	X	X	X	
Effects on stakeholders:				
HCFA and DoD	X	X		
Lead agents	X	X		
MTF management	X	X		
Physicians	X		X	
Clinical and other staff	X		X	
Dual eligibles			X	X
Other beneficiaries			X	X
TRICARE contractors	X	X		
Medicare plans, providers	X			

Individual and Group Interviews. We prepared a semi-structured interview guide containing the questions to be addressed for the topics in Table 2.2. This master list of questions is presented in Appendix A. Based on use of the question list for our first site visit, we made some minor revisions and additions to the questions, and the revised format was used as the basis for the remaining five site visits and HCFA and DoD interviews. Working from the master list, we developed several interview guides that were tailored toward topics or issues relevant to specific stakeholders. For example, we prepared separate interview guides for HCFA Central Office staff, TMA staff, and HCFA Regional Office staff.

Although we used the question list and interview guides to ensure we obtained all the desired information, we found that each interview had its own unique orientation, and we allowed flexibility for the order in which topics were addressed. The group interviews, in particular, tended to move in unpredictable directions as the group members engaged in discussion and interactions that often yielded rich insights into the dynamics underlying particular topics. Guided by the circumstances of each interview, we probed specific issues in greater depth to help guide our interpretation of the information obtained.

Provider Focus ***Groups.*** We used the focus group format to gather information on the perspectives of three key provider groups within each site: the primary care managers (PCMs) who are physicians who manage clinical care for Senior Prime enrollees, the other "front line"

clinical and support staff involved in clinical care delivery, and sub-specialty physicians who treat enrollees referred to them by the PCMs. The use of the focus group format enriched the information we collected on provider experiences in serving the dual eligibles by (1) involving a greater number of individuals than would be feasible to interview individually and (2) encouraging exchange of ideas and perspective among the group participants.

Written protocols were used to establish the format for discussion, guide each focus group's discussion, and ensure that all topics of interest are covered. A separate protocol was developed for each of the three provider groups. Depending on the site, 5 to 15 individuals participated in the focus groups. Typically, we started the focus group by asking each participant in turn to express some thoughts on his or her experiences with Senior Prime. Then we continued with specific questions covering the topic areas included in the written protocol.[10] Individuals with management responsibility were not participants in the focus groups, although some clinical managers observed the sessions at many sites. With few exceptions, the discussion was candid and thoughtful, and participants shared their experiences and those reported to them by patients.

Focus Groups -with Retiree Association Representatives. In designing the process evaluation, we decided to conduct focus groups with dual eligible beneficiaries only during the second round of site visits at the end of 2000, to learn about the perspectives of dual-eligible beneficiaries after having experience with Senior Prime plans. To obtain information on the early viewpoints of the dual eligibles, we are relying on a combination of information sources, including focus groups with military retiree association representatives and the provider focus groups. We conducted focus groups with retiree association representatives at all but one of the sites, following the same basic format used for the provider focus groups. We also elicited information from the sites' management teams about what they heard from beneficiaries as they worked with them during Senior Prime start-up, enrollment, and service delivery. The DoD Annual Beneficiary Survey, the GAO survey of dual eligible beneficiaries, and GAO focus groups with beneficiaries, which currently are being conducted, also will provide information on the baseline experiences and attitudes of dual eligibles about Senior Prime.

Interviews with HCFA and DoD Participants

Along with the site visits discussed below, the interviews of staff at the HCFA central and regional offices and staff in the DoD Office of Health Affairs and TRICARE Management Activity provide important "triangulation" of the multiple perspectives regarding the subvention demonstration. The demonstration was conceived at the top levels of government several years ago, and it was important for us to learn its history so we could understand the origins of the policy issues being argued and monitored today. In addition, we wanted to have a good "grasp" on the fullness of the specific activities and issues involved in implementing the demonstration, which could be obtained only by hearing about it from multiple perspectives.

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[10] The focus group format used for the Region 6 site differed substantially from this standard approach because the focus groups were conducted by videoconference with participants from all four MTFs. Because each group only had 15 minutes to share its views and concerns, we asked them to focus on selected topics.

Interviews were conducted with a total of 15 staff in the HCFA central and regional offices. We conducted individual interviews with Policy Office staff, who negotiated the terms of the demonstration, and with staff in the Office of Managed Care, who handle the operational aspects of certification and compliance for Medicare health plans, including the Senior Prime plans. Individual interviews and a group interview also were held with staff in the Demonstrations Office who oversee the demonstration itself. Participants in the group interview were several individuals who currently are or had been project officers for the subvention demonstration (and the VA subvention demonstration), with whom we tracked the history of subvention negotiations from inception through its inclusion in the BBA and early implementation. Finally, individual interviews (five by telephone and one in person) were conducted with staff in six HCFA regional offices, each of which is responsible for one of the demonstration sites, to learn their roles and perspectives on Senior Prime.

We interviewed 10 staff persons at Health Affairs and TMA, all of which were individual interviews except for a few that included two or three persons. Several of the interviews were with leaders or technical staff who had participated in the formulation of subvention policy and design for legislation and. the MOA, including the Health Affairs staff person who led the DoD negotiations. These interviews offered information and insights into the DoD perspective on the history of the demonstration and related issues. Additional interviews were held with TMA staff who are currently involved in the policy, operation, or oversight of the demonstration. These include the staff who provide policy and technical support to the demonstration sites on a daily basis, as well as staff in the marketing department where the Senior Prime marketing materials were prepared.

Structure of the Site Visits

The first round of site visits was performed as specified in Table 2.3. Preparation for these site visits began with a meeting with representatives of the Surgeons General for the Army, Air Force, and Navy, at which we described our plans and study design for the process evaluation. These individuals gave us contact information for the TRICARE Senior Prime points of contact (POC) in the LA Offices for the six sites, with whom we worked to schedule the site visits and organize the interview agendas. We prepared a template for a site visit agenda that we provided to each site POC (see Appendix B). Working with the template, the POC tailored the agenda to the site's unique situation and made all scheduling arrangements with the site's participants.

We provided a copy of the master interview guide to the site POC before the site visit - a strategy that allowed the sites to prepare for the topics of interest to us and enabled us to cover a great deal of information efficiently. Throughout each site visit, representatives from the LA Office, participating MTF(s), and MCS contractors were active participants in the interviews. We also conducted a group interview with just the MCS contractor staff to capture the full scope of their roles and issues. During each site visit, we obtained written materials that describe the site and its Senior Prime program.

Table 2.3
Schedule for the First Round of Site Visits, Subvention Evaluation

Site	Date of Visit
Colorado Springs site: Evans ACH, Ft. Carson Air Force Academy	19-21 April 1999
Dover Air Force Base	12-14 April 1999
Keesler Air Force Base	27-29 April 1999
Madigan Army Medical Center	23-25 February 1999
Southwest Region site: Brooke Army MC, Wilford Hall MC Reynold ACH, Ft. Sill, Sheppard AFB	22-25 April 1999
Followup informal visit to Ft. Sill and Sheppard AFB to see the facilities	5 and 7 May 1999
San Diego Naval Medical Center	20-22 January 1999

In our introductory meeting for each site visit, we indicated our desire that the site visits be a shared-learning process for RAND and the sites, and not to "grade" them on their performance. Our goal was to provide actionable information to HCFA and DoD that can help them strengthen the Senior Prime program in the future, should a decision be made to make it permanent. Following each site visit, we prepared a written report that summarizes the information obtained from the team interviews and focus group discussion and presents the key lessons and issues identified from the site visit. The six site visit reports are presented in Appendix C. Issues that have been identified will be monitored on a quarterly basis through telephone interviews and teleconference communication with the points of contact at the sites.

ENROLLMENT DEMAND

We obtained enrollment data from both DoD and HCFA sources, which we matched with each other and reconciled to ensure that the set of dual eligibles established is as complete as possible. The sources of Medicare enrollment data are the Enrollment Database (EDB) and Group Health Plan (GHP) files. The EDB file provides master enrollment records for all Medicare beneficiaries including information on entitlement, enrollment, and Medicare status. The GHP file provides specific characteristics of beneficiaries enrolled in Medicare managed care plans, including the Tricare Senior Prime plans. DoD enrollment data come from the Defense Eligibility Enrollment Reporting System (DEERS), which records basic information on each eligible beneficiary, including residence information and other demographic data. These data were obtained from Vector Research, Inc. (VRI) and include the years 1992 through 1998 for DoD retirees and their dependents that are age 65 or older as of September 30 of each year. Quarterly DoD enrollment data will be collected from VRI for the duration of the evaluation.

We created a population file from these data sources consisting of all Medicare-eligible DoD beneficiaries, including those dual eligibles currently enrolled in Senior Prime. Creating a dual-eligible population file that was as complete as possible required advanced database

merging and sophisticated algorithm programming techniques*[1]. Specifically, merging HCFA and DoD data sources required that enrollment data for all dual eligibles in the DEERS data be matched to the Medicare EDB. These two data sources use different systems for beneficiary identification, and therefore matching was done using common fields (i.e., Social Security Number [SSN], date of birth, and sex). A master file containing a unique Medicare Current Health Insurance Claim number (CHIC), Sponsor SSN, date of birth and sex was created and used to assign a common person identifier to all data source records. This file was then screened for duplicate records to establish a more accurate count of eligibles. Details of our findings on enrollment data consistency for this population are presented in Chapter 4.

PRELIMINARY COST STUDIES

In order to estimate the costs associated with dual eligible hospitalizations, the military apportions the cost of its inpatient MTF operations among each hospital case using a series of allocation rules. The cost studies reported here aim at estimating the accuracy of these cost estimates by examining the assumptions implicit in these rules. In particular, we examine whether elderly patients cost the same as non-elderly patients in the same DRG, and the rules used to apportion surgical costs and non-surgical ancillary costs. We do this by examining resources used by non-military patients.

Data Sources

California Discharge Abstracts. Hospital discharge abstracts from California were used to compare the resources used by patients 65 or older versus younger patients in the same DRG in the same hospital. California Office of Statewide Health Planning and Development (OSHPD) requires hospitals to provide a discharge abstract for each discharge during the calendar year. The discharge abstracts contain information on patient age, sex, diagnoses, procedures, disposition, expected payment source, length of stay, total charges, and DRG. DRG assignment is performed by OSHPD, and is based on the HCFA Grouper in use at the beginning of the calendar year.

We used a set of 2,039,229 discharges during calendar year 1996 from 373 California acute care hospitals. We excluded children's hospitals, psychiatric hospitals, rehabilitation hospitals, a small number of hospitals known to provide incomplete charge data[12], and 11 acute care hospitals with fewer than 50 elderly discharges or fewer than 50 under-65 discharges. Our data consists of all discharges from each included hospital except for those related to childbirth—i.e., discharges in Major Diagnostic Categories (MDC) 14 and 15.

Medicare Discharge Abstracts. Medicare discharge abstracts were used to study the method for allocation of surgical costs and ancillary costs among inpatients. Medicare discharge abstracts were taken from the calendar year 1996 Medicare Provider Analysis Review (MEDPAR) file, which contains all Medicare hospital discharges during the federal fiscal year.

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[11] A technical summary of these programming procedures are available upon request from Fu Associates.

[12] The exclusions consist of hospitals listed as 'all inclusive providers' on their Medicare cost reports and Kaiser foundation hospitals which do not use charges for billing purposes.

Medicare Cost Reports. We used the Medicare cost reports to estimate costs for our MEDPAR sample. We used the PPS XII cost report file which contains data on hospital cost report periods ending between Sept 30, 1995 and Sept. 29 1996. These reports provide estimates of the total cost of, and charges for, services delivered in each ancillary department and the per diem costs in routine care and special care units.

We selected only short-term acute care hospitals participating in the Prospective Payment System and excluded those with bad data. In particular, we deleted "All Inclusive Providers", hospitals that did not file a full cost report, and those hospitals that reported intensive care days on the MEDPAR, but did not separately report the costs associated with that care on their cost report. Our file available for analysis thus contains 4,145 hospitals with a total of 9,850,237 hospital discharges. In the work reported here, we analyze only surgical cases which reduces the file to 3,927 hospitals with surgical cases and 2,947,244 surgical discharges.

Measuring cost

For the comparison of costs between the elderly and non-elderly, we use charges as our surrogate for costs. In this analysis, we control for DRG and length of stay within the hospital. Patients in the same DRG in the same hospital with the same LOS, should be using a similar mix of wards and should require services from similar ancillary departments. Consequently, we believe that the charges for patients in the same DRG and with the same LOS should be proportional to cost.

For the analysis of surgical costs, we use the departmental accounting method.[13] The cost report data were used to generate ratios of cost to charge for each of 12 ancillary departments and to estimate the per diem cost of routine care and the per diem cost of care in intensive care unit and in a coronary care unit. To estimate ancillary costs for the case, ancillary charges for the case are first aggregated into the 12 departments for which ratios of cost to charges are calculated. The charges in each department are then multiplied by the cost to charge ratios and then summed across departments. This method has been compared to the, presumably better; relative value method and found to be a reasonable way of estimating average costs at the DRG level with-in hospitals.[14] In particular, for 70 percent of DRGs, estimated cost was within 10 percent of that calculated with RVUs.

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[13] Newhouse, Joseph P., Shan Cretin, and Christina J. Witsberger, "Predicting Hospital Accounting Costs," *Health Care Financing* Review, Vol. 11, No. 1, Fall 1989, pp. 25-33.

[14] Swartz, Michael, DW Young, R Siegrist, "The Ratio of Costs to Charges: How good a basis for estimating costs?", Inquiry, Winter 1995-96

Chapter 3

POLICY FRAMEWORK FOR THE DEMONSTRATION

During the interviews conducted with the key staff at HCFA and the DoD Tricare Management Activity (TMA), we gathered information on the history of negotiations and options considered by participants as they designed the subvention demonstration. This history highlights the complexity of the demonstration, and it reveals that many of the issues being debated today were central to the early negotiations that culminated in the BBA provisions and MOA for the demonstration. It is important to interpret evaluation findings from both field work and data analysis in the context of the policies and priorities that guided the MOA negotiations and demonstration design. This chapter lays out the basic issues and interests for the parties involved, which will continue to be relevant in the future, if the program become permanent.

A relatively long history precedes the establishment of the DOD-Medicare subvention demonstration by the Balanced Budget Act of 1997. The DoD has explored, for many years, options to expand military health benefits for its older beneficiaries who are eligible for Medicare. Approaches considered ranged from testing a managed care program that DoD would manage internally, as a simulation of Medicare managed care, to fee-for-service or managed care programs that would operate within the Medicare structure. The latter options require formal agreement between HCFA and the DoD for provisions on structure, processes, performance requirements, and financial terms that are consistent with both DoD and Medicare policy.

The DoD initiatives have been stimulated, at least partially, by the activities of military retiree associations, which have identified as a top priority the need to improve access to military health care for Medicare-eligible DoD beneficiaries. The retiree organizations are seeking action by the DoD to deliver on its promise that military personnel would be provided health care coverage for life. For example, the Military Coalition is a group of 30 military, 'Veterans, and uniformed services organizations that has encouraged Congress to enact legislation for the DoD subvention demonstration. [15] In addition, many retiree organizations have supported health coverage initiatives for Medicare-eligible beneficiaries at the national, regional, and local levels, working actively with the DoD, LA Offices, and MTFs.

Discussions between the DoD and HCFA about DOD/Medicare options were undertaken at several points during the past few years, beginning when the DoD approached HCFA with the basic concepts for the managed care and provider contract models being tested in this demonstration. Their discussions generated a preliminary Memorandum of Agreement on many aspects of the subvention design well before the BBA was enacted in 1997. The BBA provisions for the demonstration reflect the issues raised in those earlier discussions, and they build upon at least some of the terms on which DoD and HCFA had reached agreement in the preliminary MOA. After the BBA authorized the subvention demonstration, DoD and HCFA renewed

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[15] Reported in testimony to the Senate Armed Services Committee Subcommittee on Personnel by CDR Mike Lord, March 11, 1998, published on the Military Coalition website.

negotiations to modify the MOA to reflect the BBA requirements and to finalize the ground rules for the design, implementation, and evaluation of the demonstration.

The establishment of a mechanism for financial subvention-the transfer of funds from HCFA to DOD-creates opposing financial interests for these two government bodies, even as they share commitments to provide access to quality health care services for their beneficiaries. The interests of HCFA and DoD have influenced the legislative requirements established in the BBA, as the Congress defined a balanced program that protected the government from increased costs (based on its own priorities). Within the framework of the BBA requirements, HCFA and DoD have negotiated compromises between their respective interests that define both the form of the MOA for the demonstration and some issues that remained unsettled as the demonstration proceeded into operation. As we discuss in Chapter 5, the legislative and MOA terms and related issues had visible effects on the sites as they enrolled beneficiaries in Senior Prime, established their service network of providers, began delivering health care services, and undertook Medicare compliance activities.

PRINCIPLES AND GOALS FOR HCFA AND DOD

Through review of the BBA and MOA, and interviews with the HCFA and DoD staff who had been involved in the subvention negotiations, we have identified three basic principles for each organization that appeared to drive its approach to negotiations and positions on specific issues. We summarize these principles here. Then in the next section, we discuss how the principles were articulated in the design of the Senior Prime program, through provisions of either the BBA or MOA. Finally, we briefly discuss their implications for Medicare Partners.

HCFA has responsibility for the integrity of the Medicare program, including such functions as ensuring effective service to beneficiaries for Medicare-covered benefits, timely and appropriate payments to Medicare providers, protection against fraud and abuse, and ensuring the financial viability of the program. In this context, from HCFA's perspective, the subvention demonstration needed to conform to three basic principles that, indeed, are important factors for all Medicare policy formation. The subvention had to be structured to (1) protect the solvency of the Medicare trust funds, (2) provide for beneficiary choice and protections, and (3) ensure effective plan performance. These requirements effectively served as constraints on the definition of many aspects of the subvention design.

At the same time, the military health system is seeking ways to better serve its Medicare-eligible retirees and dependents, who continue to be eligible to use MTF services. The DoD pursues this goal within the framework of the dual mission of the MHS to maintain readiness for wartime medical care needs and to provide peacetime health care services for active duty personnel, dependents, and eligible retirees. The DoD has encouraged authorization of a subvention demonstration to test how well alternative models can achieve three basic principles that guide DoD health policy formation. From the perspective of the DoD, the subvention should (1) contribute to fulfilling the moral obligation to provide DoD beneficiaries health care for life, (2) maintain budget neutrality in the military health system, and (3) strengthen DoD's capability to provide cost-effective managed care in the TRICARE program.

NEGOTIATING SENIOR PRIME DESIGN

The BBA specified several provisions for Senior Prime explicitly, but it left many program design details to the Department of Health and Human Services and the Department of Defense, directing the two Secretaries to define those provisions in a Memorandum of Agreement. In this discussion, we distinguish which provisions are defined in the BBA or the MOA. Yet our primary focus is on the motivations of the two Departments and how they translated into Senior Prime program design, whether the terms were established in the BBA or the MOA.

Application of HCFA's Principles to Senior Prime

Protect the Medicare Trust Fund. This principle was reflected in HCFA's steadfast insistence during negotiations that the demonstration must not increase costs for the Medicare program. This is such a basic issue that the BBA contains several relevant provisions, including the requirement that DoD meet its historical LOE for space-available care before it is reimbursed for additional services, the terms for a discounted capitation rate and identification of related exclusions (medical education, disproportionate share, and a portion of capital costs), and provisions for actions by the Comptroller General if the demonstration increases Medicare spending. The BBA also sets caps on aggregate amounts to be reimbursed from HCFA to DoD, stating the dollar amounts for each demonstration year. The MOA contains specific provisions for putting each of these provisions into practice during the demonstration, including a provision for risk adjustment that the BBA does not address explicitly.

Beneficiary Choice and Protections. Beneficiary choice involves the freedom of Medicare beneficiaries to make informed decisions on enrollment in Senior Prime and to participate actively in their health care. The "protections" provisions are intended to ensure that enrollees are obtaining needed care and, when problems arise, a well-defined process is available to resolve the problems fairly. These provisions are specified in the Conditions of Participation for Medicare+Choice plans, which are their performance standards. Examples are beneficiary information during enrollment, prohibitions against discriminatory marketing practices, and appeals and grievance processes. The BBA requires that Senior Prime plans meet all requirements of Medicare+Choice plans under Part C of Title XVIII, including the conditions for participation. It also authorizes the Secretary of DHHS to waive requirements if the waiver reflects the unique status of the DoD as a federal agency or is needed to carry out the demonstration. The DHHS (represented by HCFA) allowed a few exceptions or waivers in the MOA, none of which relate to beneficiary choice or protections.

Ensure plan performance. The Conditions of Participation for Medicare+Choice plans defines the requirements for plan performance. Relevant provisions include organizational structure and resources, adequacy of provider networks, availability and accessibility of services, utilization management, quality management, medical records, and continuity of care. HCFA allowed waivers for financial viability and planning, state licensure for military physicians (who must be licensed in one state, which usually is not the state of current assignment) and the 30-minute/30-mile limit access standard if enrollees accept the waiver. HCFA has waived the requirement that Senior Prime plans submit an annual Adjusted Community Rate proposal for

the second and third demonstration years, although it did not waive the requirement for the first year.

Application of DoD's Principles to Senior Prime

Fulfill promise to DoD beneficiaries. Senior Prime has been of interest to DoD for several years as a model that could enhance access to MTF services for some of the Medicare-eligible-DoD beneficiaries. This option may be of particular value to lower income retirees who would be able to use MTF services with no out-of-pocket costs, replacing private Medigap supplemental insurance that is more costly to them.

Maintain budget neutrality. In contracting with Medicare for Senior Prime plans, the DoD has accepted the financial risk for cost-effectively managing its enrollees' health care needs within a fixed capitated payment structure. The ability of DoD to maintain budget neutrality will be determined in large part by: (1) the capability of the sites' care management activities to achieve a cost-effective service mix, and (2) the sites' ability to deliver service efficiently. It will also be determined by establishing reasonable payments for any increase in their responsibility for the health care of dual eligibles. DoD accepted the need to protect the Medicare trust funds, including the BBA provisions that DoD would maintain a financial share equal to its LOE and other constraints the BBA placed on the terms for payments to DoD. Achieving agreement on details of the financial terms, which would ultimately determine the effects on DoD finances, was one of the most complex aspects of the MOA negotiations. Even as Senior Prime began operation at the sites, many of the details were being refined by DoD and HCFA, e.g., the methods for interim payment, annual reconciliations, and risk adjustment.

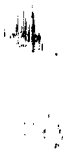
Strengthen managed care capability in TRICARE. One of the unique aspects of the subvention demonstration for the DoD is the accountability of the Senior Prime plans and participating MTFs to an external body (HCFA) that expects the participating Senior Prime plans to meet its performance requirements, provides payments for the services provided to enrollees, and monitors the plans' performance as Medicare contractors. DoD expected that this external accountability would stimulate collaborative efforts between the LA Offices and MTFs at the sites to strengthen managed care practices and reduce unnecessary care or inefficiencies for Senior Prime enrollees-and that many of these practices ultimately would be applied to TRICARE Prime. The practices required for Senior Prime, for example, enrollment procedures, quality or utilization management, and grievances and appeals processes, differ somewhat from TRICARE Prime procedures. DoD is interested in learning which of the Medicare practices might be useful in the larger TRICARE Prime environment.

NEGOTIATING MEDICARE PARTNERS

The BBA contains one brief paragraph that allows additional Medicare+Choice plans to be included in the demonstration, and it specifies that these plans may pay DoD facilities to provide health care services to Medicare-eligible military retirees or dependents. The MOA defines the details of this permissive BBA provision in the form of Medicare Partners.

The Medicare Partners terms were debated actively due to some basic disagreements between HCFA and DoD. HCFA preferred to implement Senior Prime, reflecting the growing emphasis on managed care in the Medicare program. HCFA staff were concerned that the DoD

treatment facilities would prefer to pursue Medicare Partners agreements as an easy way to obtain a fee-for-service source of revenue that involved less financial risk than Senior Prime. The OMB agreed with HCFA's preference for the managed care model, when it entered the MOA negotiations. DoD was seeking more than one subvention option, however, recognizing that an MTF-based service delivery model like Senior Prime is only a partial response to retirees' expectations for health care coverage, given that fewer than half of these older beneficiaries live in MTF catchment areas. The agreement reached was to delay initiation of Medicare partners at each site until at least 90 days after the site started health care delivery under Senior Prime, thus allowing DoD to test both models while responding to HCFA's concern.



Chapter 4

THE SUBVENTION SITES AND SENIOR PRIME ENROLLMENTS

THE SITES AND THEIR MARKETS

The six subvention demonstration sites were selected by the DoD, with approval by HCFA, to represent a diversity of characteristics for the participating MTFs and the Medicare managed care markets in which they are located. Site selection was guided by a number of criteria, including: (1) Medicare-eligible DoD population within the MTF's catchment area; (2) current MTF enrollment; (3) level of specialty services offered at the MTF; (4) inpatient capacity; (5) commercial Medicare HMO penetration; (6) maturity of TRICARE Prime program; (7) information systems capability; and (8) geographic diversity. This diversity in site characteristics, which are described in this chapter, has generated rich comparative information for the evaluation. We recognize, however, that these six sites and ten MTFs may not be representative of the MHS as a whole. Therefore, we interpret the evaluation findings with caution as we consider implications for the types of locations and treatment facilities that may be appropriate candidates for participation in a larger program.

Demonstration Site Participants and Relationships

The treatment facilities operated by the three military Services are the organizational and resource foundation for the MHS. The MTFs are managed as components of medical command structures, with differing structures across the Services.[16] The facilities are organized and staffed to support the primary mission of the military health system to maintain a fit and healthy fighting force. When TRICARE was introduced to lead the peacetime health care mission, a separate organization was established that is operated in the field by regional LA Offices. TMA serves policy, support, and oversight functions for this system. The Lead Agents do not have line authority over the MTFs, rather serving roles of coordination, facilitation, and communication with the MTFs for the management of care for DoD beneficiaries. Similarly, TMA does not have authority over the Lead Agents.

The sites for the subvention demonstration are located in six different TFUCARE regions. Each regional LA Office is designated as the Senior Prime plan for the site in its region, and HCFA holds the LA Offices accountable for fulfilling Medicare requirements for plan performance. Using a private health plan model, the Lead Agent is responsible for all operational functions of the Senior Prime plan, and the participating MTF(s) serve as the primary provider(s) of clinical care services for enrollees. Thus, Senior Prime is requiring a stronger leadership role for the Lead Agents than they perform for TRICARE.

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[16] The Army Surgeon General heads the Army medical command, within which the MTF commanders report upward through regional medical commands. The Navy has a similar structure, although MTF commanders at Marine bases also have "dotted line" reporting relationships to the base commanders. Air Force MTF commanders report directly to the line commander at the bases where the MTFs are located.

The third key participant at each Senior Prime site is the MCS Contractor, which is contracted with TMA to perform many of the administrative functions for the TRICARE program, working closely with the LA Office. The MCS contractor also performs these functions for the Senior Prime plan, including maintaining a network of civilian providers, marketing, enrollment, beneficiary services, utilization management, and claims processing. The contract, or establishes contracts with the Senior Prime network providers for services that the participating MTF(s) do not provide, such as services of sub-specialty physicians, skilled nursing care, home health, durable medical equipment. TMA currently is using cost-plus contracts to pay the MCS contractors for functions they perform for Senior Prime, because it was difficult to anticipate in advance what contractor tasks and workload requirements would arise.

Four MCS contractors support the demonstration sites' activities. Foundation Health Federal Services (FHFS) is the contractor for three of the subvention sites - Region 6, San Diego NMC, and Madigan AMC/Region 11. TriWest Healthcare Alliance serves the Colorado Springs site, Humana Military Healthcare Management serves the Keesler AFB site, and Sierra Military Health Services, Inc. serves the Dover AFB site.

The payment mechanism for the Senior Prime plans, and the apparent financial risk assumed by each participating entity, differ substantially from those of private Medicare health plans. Any capitation payments from HCFA are paid to TMA, which then allocates the payments to the individual military Services. It has not yet been determined how payments will be made to the MTFs for the costs they have incurred. In theory, TMA and the MTFs are assuming the financial risk because TMA is paying for all services provided by Senior Prime network providers, and the MTFs are incurring the costs for services they provide to enrollees. The LA Offices, unlike private health plans, assume no financial risk for management of care for Senior Prime enrollees. In practice, however, the flow of funds to the MTFs occurs through a complex budgeting process, where it often is difficult to observe direct relationships between changes in programs and related budgetary support from DoD. These complexities need to be taken into account when assessing the financial performance of this demonstration. . .

Characteristics of the Site MTFs

Some of the basic structural characteristics of a medical facility are the size of the population it serves, the size of the facility, and the facility's involvement in graduate medical education. As shown in Table 4.1, the MTFs participating in the Senior Prime demonstration vary substantially on these dimensions. Dover AFB, the smallest MTF, has no inpatient service capacity, a small population base, and no involvement in graduate medical education (GME). Four other MTFs – Evans ACH, USAF Academy, Sheppard AFB, and Reynolds ACH – also are relatively small facilities without GME programs. At the other extreme, the Naval Medical Center of San Diego has a large population base, a large inpatient capacity, and several GME programs. Keesler AFB, Madigan AMC, Brooke AMC, and Wilford Hall MC also are larger facilities with GME programs. The larger MTFs tend to be in locations with larger Medicare/DoD dual-eligible populations, and compared with the smaller MTFs, the dual eligibles tend to be larger shares of the total catchment area DoD beneficiary populations.

Two of the demonstration sites have more than one participating MTF. In Region 6, the LA Office works with four MTFs in two separate market locations. Brooke AMC and Wilford Hall MC, both located in San Antonio, are large specialty hospitals that share a service area with

large dual-eligible populations. Reynolds ACH and Sheppard APB are in rural locations near the Texas-Oklahoma border with relatively small dual-eligible populations. In the Colorado Springs site, the Central Region LA Office works with Evans ACH and the USAF Academy, both in the Colorado Springs market. In the other four sites, the LA Office has a one-on-one working relationship with an MTF and, with the exception of Dover APB, the Lead Agent is also the commander of the MTF. Dover is located in Region 1, where the MTFs with inpatient capacity are clustered in the National Capital Area, and the LA Office is housed at Walter Reed AMC.

Table 4.1
Characteristics of the Treatment Facilities in the Demonstration Sites

MTF	Number of Dual Eligibles	Number of Active Duty	Ratio of AD/DE	Annual Dispositions	Average Census*	Graduate Medical Education
Dover AFB	3,730	4,184	1.12			No
Keesler AFB	7,601	10,473	1.38	5,115	69.7	Yes
Madigan AMC	19,565	24,624	1.26	10,686	117.1	Yes
Colorado Springs, CO						
Evans ACH, Ft. Carson	6,162	15,621	2.54	5,226	37.4	No
USAF Academy	8,184	12,485	1.53	2,201	12.2	No
Region 6 site						
Brooke AMC	21,220	12,989	0.61	9,493	129.8	Yes
Wilford Hall MC	13,967	18,385	1.32	15,404	189.2	Yes
Sheppard AFB	2,592	3,875	1.49	2,091	33.1	No
Reynolds ACH, Ft. Sill	4,744	14,906	3.14	3,229	22.8	No
Naval MC San Diego	36,184	68,789	1.90	21,983	200.6	Yes

* Average daily census, which the MTFs refer to as average daily patient load (ADPL).

The Medicare Markets Where the Sites Are Located

The six demonstration sites are located in Medicare markets with a diversity of managed care profiles. As shown in Table 4.2, there is substantial Medicare managed care in the markets for the Colorado Springs, San Diego, and Madigan sites, and in the San Antonio portion of the Region 6 site, all of which have large percentages of Medicare health plan enrollees. They also have the most plan competition, measured by both number of HMOs and the largest HMO market share.

The average 1999 monthly Medicare+Choice capitation base rates vary moderately across the sites.[17] The Senior Prime base capitation rates are calculated as modifications to these Medicare+Choice county rates, as described in Chapter 1. The highest average rates are $560 per member per month for the Keesler AFB market and $528 for the San Diego NMC market. The Texoma market has the lowest average rate of $38 1 per member per month.

[17] To establish actual payments to a Medicare+Choice organization, these base rates are adjusted by the demographic factors for the organization's enrollee mix.

Table 4.2
Medicare Managed Care Market Profiles for the Demonstration Sites

	1999 Medicare Capitation Rate *	Number of Medicare Beneficiaries	Percentage of Medicare Beneficiaries Enrolled	Number of Medicare HMOs >1% Share **	Largest HMO Market Share
Dover APB	$479	148,361	6.1%	1	59.7%
Keesler AFB ***	560	108,501	12.3	3	78.5
Madigan AMC	422	373,649	28.2	6	37.2
Colorado Springs	426	146,363	38.6	6	55.8
Region 6					
San Antonio	472	203,871	33.8	4	41.5
Texoma area	381	54,199	4.2	2	70.8
San Diego NMC	528	339,309	49.4	5	62.3

SOURCE: Analysis of January 1999 Medicare market penetration data, published 1999 Medicare capitation rates, DoD data on zip codes in MTF catchment areas, zip code/county crosswalk files.

* Average Medicare+Choice base rates for the counties in each catchment area, weighted by number of beneficiaries in each county. These are NOT the base capitation rates for the subvention sites.

** The number of HMOs does not include the Senior Prime plan.

*** The only substantial Medicare health plan enrollment is on the edge of the Keesler service area in Alabama.

ENROLLMENT DEMAND FOR SENIOR PRIME

Like other Medicare beneficiaries, dual-eligibles can be covered under a wide array of health insurance plans. These include Medicare HMOs, supplemental insurance, and (very rarely) Medicaid. Their options are further complicated because they have access to care in the MTF. The introduction of TRICARE Senior Prime elevates enrollees' priority for MTF services, and it makes available TRICARE Prime providers, care management services, and supplemental benefits not covered by FFS Medicare-all this with no beneficiary premium. In this section, we examine some of the early trends in Senior Prime enrollment.

Monthly Enrollment

Table 4.3 reports Senior Prime enrollment figures overall and by demonstration site from August 1998—when enrollment began at Madigan-through June 1999. As of June, there were 25,627 dual eligibles enrolled in Senior Prime. Enrollment varies considerably by sites, ranging from a low of 705 enrollees in Dover to a high of 12,461 in the San Antonio group over this period. Enrollment appears to have leveled off at all sites, with the exception of Colorado Springs and San Diego, which were the last to begin enrollments.

Table 4.3
Senior Prime Enrollment by Month

Month-Year	Total	Demonstration Site: San Diego	Colorado Springs	Dover	Keesler	San Antonio	Madigan
Aug-98	0	0	0	0	0	0	0
Sep-98	2,964	0	0	0	0	0	2,964
Ott-98	6,894	0	0	0	0	3,757	3,137
Nov-98	11,374	1,381	0	0	0	6,751	3,242
Dee-98	16,538	2,054	0	0	1,085	10,068	3,331
Jan-99	20,082	2,285	901	426	2,159	10,876	3,435
Feb-99	21,998	2,463	1,768	537	2,386	11,339	3,505
Mar-99	23,354	2,609	2,607	589	2,469	11,533	3,547
Apr-99	24,313	2,781	2,767	647	2,582	11,953	3,583
May-99	24,965	2,888	2,876	675	2,661	12,224	3,641
Jun-99	25,627	3,031	2,995	705	2,745	12,461	3,690

Table 4.4 considers the relationship between enrollment changes and planned enrollment in more detail. The meaning of "planned enrollment" varies across sites, as discussed in Chapter 1, but it does provide a benchmark for comparing the dynamics of enrollment. The table shows enrollment relative to planned enrollment. A comparison of the first month of enrollment across sites shows that all sites except Region 11 enrolled less than 35 percent of their planned enrollment in the first month of operation. Region 11 enrolled almost 90 percent in September 1998. We obtained information during our site visits that explains at least part of the early enrollment patterns. The Region 11 site reported that its strategy of bulk enrollment created operational problems for its clinics; several other sites reported that, learning from the Region 11 experience, they staged enrollments over the first few months.

Table 4.4
Senior Prime Enrollments Relative to Planned Enrollments

Month	San Diego	Colorado Springs	Dover	Keesler	San Antonio	Madigan
Aug-98	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Sep-98	0.0	0.0	0.0	0.0	0.0	89.8
Ott-98	0.0	0.0	0.0	0.0	29.6	95.1
Nov-98	34.5	0.0	0.0	0.0	53.2	98.2
Dee-98	51.4	0.0	0.0	35.0	79.3	100.9
Jan-99	57.1	26.5	28.4	69.6	85.6	104.1
Feb-99	61.6	52.0	35.8	77.0	89.3	106.2
Mar-99	65.2	76.7	39.3	79.6	90.8	107.5
Apr-99	69.5	81.4	43.1	83.3	94.1	108.6
May-99	72.2	84.6	45.0	85.8	96.3	110.3
Jun-99	75.8	88.1	47.0	88.5	98.1	111.8

Another question raised by these enrollment patterns is whether sites' planned enrollment levels were too low or too high. For example, does the rapid achievement of planned enrollments in Region 11 indicate that the site could have achieved larger enrollments under a higher target? Or were the planned enrollments of some sites too high? In considering these questions, it is important to distinguish between the levels of enrollments and the speeds at which those levels are reached. The Senior Prime financial provisions create incentives for sites to maximize early enrollments, yet operational pressures call for staged enrollments.

Senior Prime Market Share

We are interested not only in aggregate enrollment, but enrollment in proportion to the number of dual eligibles. In some sites, there is a divergence between the geographic boundaries defined by HCFA and DoD as the Senior Prime service areas and the traditional catchment areas associated with each MTF. In Appendix D we present maps that show the overlay between the catchment areas and demonstration service areas. Each zip code is coded to designate whether it is in a catchment area only, demonstration service area, or both. At Dover, Keesler, and Colorado Springs, the demonstration service areas and catchment areas correspond closely." In San Diego and San Antonio, there are larger differences that reflect the service area decisions made by TMA and the sites during the plan certification process. Table 4.5 quantifies these differences in terms of beneficiary populations.

Table 4.5
Counts of Dual Eligible Beneficiaries by Service Area

	Number of dual eligibles living in:		
Site	Demo Area Zip Code	Catchment Area Zip Code	Demo or Catchment Zip Code
Colorado Springs	18,724	18,701	18,724
Dover	5,445	5,445	5,445
Keesler	10,364	10,364	10,364
Madigan	30,756	30,754	30,756
San Diego	44,295	50,314	52,335
San Antonio	40,671	58,047	58,074
Other *	1,802,082	1,778,712	1,776,639

* All other dual eligibles in the total DoD beneficiary population.

Table 4.6 shows the implied penetration rates for Senior Prime using demonstration service area populations as denominators. This figure slightly exaggerates the actual penetration rate, since some beneficiaries who live outside the demonstration service area can "age-into" Senior Prime. San Diego has the lowest rate at 6 percent, compared with San Antonio at 24

[18] The Colorado Springs zip code 80138 was not in our mapping software's master zip code file and therefore does not appear on the Colorado Springs map. This accounts for the differences between the population sizes based on demonstration zip codes and catchment zip codes.

percent. There are many possible reasons for the discrepancy, including differences in MTF capacity, the desirability of Senior Prime and the MTFs relative to local Medicare health plans or fee-for-service providers, and Senior Prime marketing efforts.

Previous Source of Enrollment

Among enrollees, it is worthwhile to consider the previous locus of care. This is important since it is possible that Senior Prime could have adverse consequences for Medicare providers. Table 4.6 also shows, among enrollees, their previous sector of care choice in August 1998—just prior to enrollment at most sites. Overall, 35 percent come from other Medicare health plans. However, there is substantial variation by sites. For example, few Keesler participants came from a Medicare health plan, compared with 56 percent in Colorado Springs. While there is some correspondence between these figures and Medicare plan market shares, per Table 4.2, there also are other explanations. For instance, three Medicare plans left the Dover market before Senior Prime began, and similarly, two plans left the Colorado Springs market.

Table 4.6
Senior Prime Enrollment Share and Previous HMO Experience of Enrollees

	All Sites	Colorado Springs	Dover	Keesler	Madigan	San Diego	San Antonio
Senior Prime enrollment (March 1999)	23,339	2,585	589	2,470	3,548	2,611	11,536
% dual eligibles in Senior Prime	17%	16%	13%	26%	12%	7%	31%
% dual eligibles in Medicare HMO	31%	36%	7%	1%	30%	44%	26%
% Senior Prime enrollees previously in Medicare HMO	35%	56%	19%	0%	35%	35%	40%
Max. number of enrollees from a single HMO	n/a	642	85	2	846	595	2,714

Sources: Medicare GHP master file, matched Medicare/DoD beneficiary data, HCFA summary market penetration files

Note: "% of dual eligibles in Senior Prime" refers to the period June 1999. "% of dual eligibles in Medicare HMOs" is a measure of Medicare HMO penetration into the dual eligible market in August 1998, just prior to the beginning of Senior Prime enrollment. Dual eligibles must have been covered by Part A in August 1998 to be included in this computation. "% Senior Prime enrollees previously in a Medicare HMO" is a measure of the previous choice (HMO or FFS) by Senior Prime enrollees before the demonstration began. It is computed by taking all Senior Prime eligibles in June 1999, and identifying the fraction who were enrolled in a Medicare HMO in August 1998. For this calculation, only Senior Prime enrollees eligible for Medicare as of August 1998 were included-i.e., it excludes those who age-in to Senior Prime after August 1998. "Max. number of enrollees from a single HMO" refers to the plan in each site with the most members in August 1998 who subsequently enrolled in Senior Prime (by June 1999).

Table 4.6 also shows the percentage of Senior Prime enrollees coming from HMOs with the percentage of all dual eligibles enrolled in HMOs in each market. In all cases except San Diego, it appears that TSP draws disproportionately from previous Medicare HMO subscribers. In certain areas, some Medicare HMOs loss substantial numbers of enrollees. In one case in San Antonio, a plan lost 2,714 members to Senior Prime. Further, approximately 90 percent of the

movement from Medicare HMOs into Senior Prime is accounted for by the largest two plans in all markets except Keesler. (For Keesler, virtually all enrollees came from the fee-for-service sector, so this figure is neither precise nor germane.) Whether this concentration of enrollment has adverse impacts on the care for the rest of the Medicare population is also an area for further investigation.

Data Issues in Measuring the Dual-Eligible Population

Person-Level Enrollment File and Summary Tables. Once the initial database merge and screening of the HCFA/DoD databases was completed, it was determined that 1998 Enrollment Data would be used as the person-level enrollment file because it represented the most current and complete DoD enrollment data available from VRI. In addition to the person-level enrollment file, summary tables were developed from the 1998 data for use in the first phase of the Medicare Subvention enrollment analysis. Table 4.7 reflects results using the September 1998 DoD Enrollment file as the initial dual eligible population. There is a difference of 485,895 records (non-match rate of 25 percent) after the DoD data are matched to HCFA data sources. The match rate of 75 percent is consistent with the rate from the initial phase of the project. Further investigation of the characteristics of those records that did not match is being undertaken-

Table 4.7
Summary Dual Eligible Counts

Population	Total Dual Eligibles
1998 DoD Enrollment Data Only	1,952,337
1998 DoD Enrollment Data Matched Against HCFA Data Sources	1,466,442
1998 DoD Enrollment Data Matched Against HCFA Data Sources (Excludes those records coded as ineligible for DoD benefits.)	1,193,294

Summary of Senior Prime Enrollee Counts. Population counts for the enrollees were created by using the GHP file to identify those dual eligibles enrolled in Senior Prime. Table 4.8 displays the Senior Prime enrollee population by demonstration site. The final column differs from the previous column only in that it excludes individuals classified as ineligible-in the DoD data-to receive benefits from DoD. A significantly high percentage of the current Senior Prime enrollees are classified as ineligible for DoD benefits. Table 4.9 illustrates the frequency and percent of those current enrollees (by demonstration site) that according to DEERS data are classified as ineligible for DoD benefits.

Table 4.8
Comparison of Enrollment Counts Using Different Matching Algorithms

Demonstration Site	Total Dual Eligibles from the GHP	Total Dual Eligibles from the GHP that Matched with DoD/EDB Data	Total Dual Eligibles in GHP with Matched DoD/EDB Data (Excludes records coded as ineligible for DoD benefits.)
San Diego	2,611	2,089	1,340
Colorado Springs	2,585	2,241	2,207
Dover	589	504	406
Keesler	2,470	2,093	1,571
San Antonio	11,536	9,945	6,376
Madigan	3,548	3,059	1,748
Totals	**23,339**	**19,931**	**13,648**

Initial feedback from VRI indicates that the high frequency of these individuals stems from DEERS programming inconsistencies that classified some dependents as ineligible. VRI has briefed the government on this issue already and a correction will be integrated after a systems conversion and Y2K priorities are completed. We quote here the documentation provided by VRI as the official explanation for this problem:

> "We [VRI] discovered this issue in March 1999 when comparing the Defense Medical Information System @MIS)-derived eligibility field for selected beneficiaries between FY 1997 and FY 1998. According to this field, it appeared that several retiree family members, and survivor beneficiaries became ineligible between FY1997 and FY 1998. Because this is inconsistent with the current benefit structure, we analyzed the issue further and concluded that it was related to a new use of a code in the Defense Eligibility and Enrollment Reporting System (DEERS) population data Medical Eligibility-CHAMPUS Privilege field that the DMIS population processor was not equipped to handle. This code appeared to be related to TRICARE Senior Prime enrollees.
>
> "In April, we began discussing this issue with DEERS to confirm our understanding of the new code and to determine how the CEIS population processor should be modified to handle the new code. At the same time we notified the Corporate Executive Information System (CEIS) Program Management Office (PMO), the office responsible for processing the DEERS population data and making them available to the Military Health System (MHS) community. The CEIS PMO has indicated that changes to the population processing logic will be implemented after current efforts to migrate the population processor to Y2K-compliance are completed in July. Concurrent with notifying the CEIS PMO, we notified Tri-Service and TRICARE Management Activity (TMA) representatives to the Population and Resource Projection Working Group (PRPWG) at the April meeting of the PRPWG. The PRPWG is the working group responsible for overseeing functional and analytical currency of the Managed Care Forecasting and Analysis System (MCFAS) - the population forecasting tool of CEIS. At their recommendation, we are adjusting the MCFAS population processing for version 12.1 (to

be released in August) to recognize the eligibility of the affected beneficiaries in the DMIS-processed DEERS data."

The discussion is a notification that was posted in April 1999 to users of the CEIS Managed Care Forecasting and Analysis System (MCFAS) to alert them to the issue. A more detailed discussion of this issue, including the number of beneficiaries affected in each catchment area, is available upon request.

Table 4.9
Ineligibility for DoD Benefits by Site

Demonstration Site	Total Dual Eligibles from GHP that Matched with DoD/EDB	Total Number of Dual Eligibles Classified as Ineligible for DoD Benefits	Percentage
San Diego	2,089	749	35.9%
Colorado Springs	2,241	34	1.5%
Dover	504	98	19.4%
Keesler	2,093	522	24.9%
San Antonio	9,945	3,569	35.9%
Madigan	3,059	1,311	42.9%
Totals	**19,931**	6,283	31.5%

Chapter 5

EARLY EXPERIENCES IN THE DEMONSTRATION

The first tasks undertaken by TMA and the demonstration sites were the design of the Senior Prime program, at both the corporate and site levels, and the preparation of written applications for certification as Medicare managed care plans. After the Medicare application for each Senior Prime plan had been submitted, and HCFA had deemed them complete, HCFA conducted a certification site visit to review the application and related documents at the site. As each application was approved by HCFA, a contract letter was sent to DoD confirming the establishment of the Senior Prime plan. The contract defined the plan's service area by county and zip code, specified the waivers from Medicare rules established for the subvention demonstration, and approved the Senior Prime marketing materials and the form for civilian network provider contracts. Each site began marketing and enrollment activities as soon as the DoD received its Medicare contract from HCFA.

As specified in the MOA, no Medicare Partners activities were to be initiated at a demonstration site until at least 90 days after start of service delivery under its Senior Prime plan, subject to satisfactory progress of the Senior Prime program.[19] Within these requirements, HCFA and DoD agreed that DoD would determine when to pursue Medicare Partners agreements at the sites. At this time, no Medicare Partners activity has been undertaken. We address the current status and issues related to Medicare Partners at the end of this chapter.

MEDICARE PLAN CERTIFICATION REQUIREMENTS

To participate in Senior Prime, the demonstration sites had to meet the conditions for participation required for all Medicare+Choice plans except where the requirements have been determined to not be applicable or have been waived by the HHS/DoD MOA under authority of the BBA. Inapplicable Medicare requirements include those for fiscal soundness and requirements related to Medicare employer group health plan enrollees. Waivers were granted from Medicare-standards for (1) financial viability and planning, (2) DoD providers to meet statutory definitions and licensure requirements (as long as they are licensed in at least one state), (3) compliance with the 30-minute/30-mile primary care access standard (by obtaining waivers from enrollees who reside beyond this boundary), and (4) continued plan enrollment as Part B enrollees for those who lose Part A entitlement (because the demonstration requires that participants have both Part A and Part B coverage). Senior Prime plans complied with the following categories of standards:

- Satisfactory administrative and management arrangements, including a policy making body, adequate management systems, and an executive manager;

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[19] Satisfactory progress is defined as meeting the DoD performance measures (Attachment F to the MOA) and evidence that adequate financial systems are in place to track level of effort and reimbursement.

- Effective procedures for utilization management;
- A service delivery system capable of providing all required services, including proper licensure or certification for providers;
- Appropriate access to services and continuity of care for enrollees, including provisions to cover services through another organization in urgent or emergency situations;
- Internal quality assurance programs and external reviews, including systematic collection and reporting of performance data;
- Non-discrimination in screening of enrollees and with respect to provider participation, payment, or indemnification;
- Full disclosure of information to enrollees on the plans' benefits, features, service area, provider network, coverage policies, and other features, with all marketing materials submitted to HCFA for approval before use;
- Compliance with all requirements for processing enrollment applications, membership information, voluntary and involuntary disenrollments, payments by enrollees, and submittal of related records to HCFA;
- Compliance with standards for beneficiary protection, including grievances and appeals processes, confidentiality, and information on advance directives.

SENIOR PRIME PROGRAM DESIGN

TMA Functions and Responsibilities

The operational oversight for the Senior Prime plans is provided by TMA, which has overall responsibility for management of the TRICARE program. TMA established the Senior Prime benefits package, the basic program structure, and national marketing materials to be used by all sites, and it negotiated with HCFA the specifications for the payment system and LOE calculations. TMA developed a template for the Medicare application, which each site used to prepare the application to become a Senior Prime plan. At the same time, TMA developed the terms for roles and performance of the MCS contractor for the Senior Prime plans, which are delineated in an addition (section N) to Chapter 20 of the TRICARE Operations Manual. The contractors function under a combination of provisions in their existing TRICARE contracts and Chapter 20. The Chapter 20 provisions were reviewed in detail at a meeting with the sites' management teams and MCS contractor representatives in Spring 1998, and revisions continue to be made as issues arise during the demonstration.

Regular videoconference meetings were held with the sites to communicate TMA activities, get the sites' input on policies being developed, and help coordinate their work. Two full-time TMA staff, who have hands-on Medicare experience, provide technical support to the demonstration sites on a daily basis. TMA left to the sites the design details for the Senior Prime plans. The sites developed the local plan organizational structures and processes, guided by the HCFA Conditions for Participation for Medicare managed care and by the consultants the sites hired with TMA funding support to provide them Medicare expertise.

The MCS contractors are responsible for processing payments for network providers for their services, including the Senior Prime providers. TMA pays these claims directly and has set up a separate risk pool for Senior Prime network provider claims. The MCS contractors have subcontracted the claims processing function to two contractors, PGBA and WPS. As TRICARE was initiated in each region, there had been problems with the timeliness of claims processing that led the network providers to express dissatisfaction with TRICARE and to the cancellation of contracts by some providers. Although these problems have been resolved in most locations, they continue to discourage some providers from participating as Senior Prime contractors, as discussed below.

The Senior Prime Plans

The six demonstration sites share many common elements in their organizational structure, benefits covered, and service delivery system, but they differ somewhat in the roles and relationships of the LA Office, participating MTF(s), and the MCS contractors. In particular, the Colorado Springs and Region 6 sites were organized to accommodate multiple MTFs.

Infrastructure. The Senior Prime plans have been integrated into TRICARE at the governance level. Each site has a Senior Prime governing board, although they differ in how that board fits into the overall TRICARE governance structure. Each Senior Prime governing board has a quality committee that typically has broad jurisdiction over quality, utilization, appeals, and grievance activities. Anticipating the possibility that Senior Prime may become a permanent part of TRICARE, the sites chose governance structures that could absorb an expanded program without having to reorganize.

The Senior Prime management team in each site reports to its governing board, and each management team is led by staff in the LA Office. The sites vary substantially in the depth of staffing committed to this program. The Region 6 site has 5 full-time LA staff who have developed in-depth technical knowledge of Medicare managed care and the Senior Prime program, which they make available as a technical resource to the site's MTFs. The Colorado Springs site has a plan coordinator and 3 full-time staff to operate the program and coordinate work with the 2 participating MTFs. Other LA Offices have less staffing depth, reflecting their less complex structures, and in most of these sites, almost every LA staff person with Senior Prime responsibility also performs other TRICARE functions.

Management Leadership. The LA Office is responsible for overall management of the Senior Prime plans. The LA staff have established working teams consisting of staff counterparts from the LA, MTF(s), and MCS contractor, which work together on specific Senior Prime functions (e.g., utilization management, appeals and grievances). For clinical functions, such as quality management, the MTF staff typically have responsibility for MTF services and the contractor staff handle the network provider services. Monitoring, appeals, and Medicare compliance activities typically have been retained centrally by the LA staff with participation by the MTF(s) and MCS contractor staff. The LA Office for the Dover site (Region 1) has been implementing Senior Prime simultaneously with the entire TRICARE program. As a result, the MTF assumed a leadership role in organizing and leading Senior Prime early in the start-up, with the LA Office picking up the lead later.

The two sites with more than one MTF have more complex organizations than the other sites. The Region 6 LA Office has entered into written memoranda of understanding (MOU) with the 4 participating MTFs that formalizes the agreement between the LA and MTFs regarding their respective roles and responsibilities. The MOUs compensate for the absence of formal line authority by the LA Office. The LA Office in the Colorado Springs site is leading the program actively, drawing upon the two MTFs and the MCS contractor to build teams and collaboration on activities, but MOUs have not been used to formalize these relationships. The remaining sites also have not formalized their organizational relationships, but they have identified and reached agreement on the responsibilities of the LA, MTF, and MCS contractor in each functional area.

Benefit Package. As discussed in Chapter 1, Senior Prime health care benefits are the "richer of the Medicare or TRICARE Prime benefits," thus providing the same health benefits at all Senior Prime sites. Because outpatient pharmacy coverage is an open benefit for DoD beneficiaries, it is not a competitive advantage for Senior Prime plans, despite its popularity, because beneficiaries are free to enroll in another Medicare plan and still use this benefit.

In the more competitive Medicare managed care markets, this policy of national benefits may constrict the ability of the Senior Prime plan to compete on benefits with other Medicare plans. Non-competitiveness of benefits may be contributing to the lower-than-expected enrollment rates for the San Diego site, which is in a very competitive market with high Medicare capitation rates, and health plans offer rich benefits to attract enrollees. Capitation rates are lower in the other three markets with Medicare managed care competition - Madigan, Colorado Springs, and San Antonio - which may mitigate this issue for those locations because plans tend to offer fewer supplemental benefits. More information is needed before we can assess possible impacts on the plans' ability to attract new enrollees, which we will continue to explore in our evaluation.

Another benefit issue is two-tier cost sharing, where Senior Prime enrollees receive MTF services at no cost but they are required to pay either copayments (fixed amounts) or coinsurance (percentage of charges) for services obtained from network providers. Senior Prime enrollees must use MTF services when available and otherwise must use network providers and pay the cost sharing. Because the vast majority of Medicare health plans cover all but a small amount of enrollee cost sharing, this provision may weaken the market positions of Senior Prime sites whose enrollees use network providers regularly (e.g. the Colorado Springs site). In addition, HCFA regional offices have expressed concerns that this policy may be confusing to beneficiaries, who may not be aware of their potential financial liability, which can become quite large for coinsurance for extensive treatment. Although this two-tiered structure may look similar to a private sector point-of-service plan, it is fundamentally different because Senior Prime enrollees are not free to choose providers and the associated cost sharing. In a point-of-service plan, insured persons have lower cost sharing when they use network providers, or they may choose non-network providers if they are willing to pay higher costs.

Quality and Utilization Management System. The placement of the quality management (QM) committee high in the sites' Senior Prime governance structure reflects the importance placed on these functions by HCFA, TMA, and the demonstration sites. All sites have structured their Senior Prime QM plans and activities as extensions of the regional TRICARE quality assurance programs, and they have drawn upon existing monitoring protocols and sets of

indicators to be monitored. The QM and utilization management (UM) functions are defined as distinct aspects of a unified care management function, with the goal to provide appropriate care for enrollees at reasonable costs. In all six sites, the QM/UM team consists of clinical and administrative staff from the LA Office, each MTF in the site, and the MCS contractor. In some regions (Dover, Keesler, San Antonio), some or all of the UM functions are purchased from the MCS contractor for TRICARE, and the contractor also performs these functions for Senior Prime. In the other regions, these functions are performed by MTF staff for MTF services and by the MCS contractor for network providers.

Provider networks. The basic design of the demonstration specifies that the site MTFs are the principal providers for Senior Prime enrollees, and civilian network providers will be used only for services the MTFs do not provide. The sites differ widely in the scope of services provided by the MTFs. The medical centers (Brooke AMC, Keesler MC, Madigan AMC, San Diego NMC, and Wilford Hall MC) provide a full range of inpatient and outpatient services, including many sub-specialty services. At the opposite extreme, the clinic at Dover AFB provides only outpatient primary care and a few specialty services. The four community hospital MTFs (Evans ACH and USAF Academy Hospital in Colorado Springs; Reynolds ACH and Sheppard AFB in Texoma) provide inpatient and outpatient care, but they only have a limited number of specialty services. None of the MTFs officially provide skilled nursing facility care, home health, durable medical equipment services, or other services specifically needed by an older population.

The MCS contractors established, and now manage, contracts with the Senior Prime network providers. Community providers with TRICARE Prime contracts were the first providers tapped by the MCS contractors for participation in Senior Prime. Then they reached into the community to recruit other types of providers that were not available from the Prime network. All sites report that it was relatively easy to recruit institutional providers such as skilled nursing facilities, home health agencies, or DME suppliers because there were adequate supplies in the community and they all were Medicare-certified providers.

Challenges were faced by some sites in recruiting sub-specialty physicians who were not already participating in TRICARE Prime. Recruitment proceeded with relative ease in Region 11, San Diego, and the San Antonio portion of the Region 6 site, all of which were in large markets with managed care presence. The Dover, Keesler, and Colorado Springs sites, and the Texoma (Reynolds and Sheppard) portion of the Region 6 site, face continuing recruitment difficulties, although they were able to reach an acceptable depth of providers in their networks.

Many physicians with full private practices see no advantage to participating in Senior Prime. One reason cited for resistance by community physicians was general dislike of managed care arrangements, which was encountered in the Texoma, Dover, and Keesler markets. Physicians in the Dover, Keesler, and Colorado Springs markets also reported dissatisfaction with the low military fee schedule, late claims payments, and other negative experiences with CHAMPUS. Physicians in the Colorado Springs market remembered especially painful experiences with TRICARE. Soon after TRICARE was initiated in the region, physicians became so dissatisfied with low prices and slow payments that large numbers of them canceled contracts, and contractor had to rebuild the TRICARE provider network. Despite perceptions that military prices are low, we have been told that the prices have improved in the past few years and that they are quite similar to the Medicare Fee Schedule rates for physician services. This

issue merits further attention to verify the status of the military rates, with relevant information communicated to the medical community.

Information System Requirements and Resources

Four major functions of the Senior Prime program depend on multiple data systems operated by the DoD itself, DoD contractors, and HCFA: (1) the processing of Senior Prime enrollments, (2) the quality assurance and utilization management programs of the sites and TMA, (3) processing of payment claims for network providers and non-network providers that provide otit-of-area care for enrollees, and (4) the determination of DoD costs, level of effort, and capitation payments from HCFA. The DoD systems include data storage systems (DEERS enrollment system, CEIS, Ft. Detrick, MEQS, and HCSR database) and data capturing systems (the MTFs' CHCS clinical data and ADS ambulatory care data systems, and the MEPRS data on MTF workloads and finances). Contractors' systems include the MCS contractors' enrollment systems and the EAPP and CRIS claims processing systems operated by WPS and PGBA, respectively. The HCFA Medicare Processing Center (MPC) is an external system that processes applications for Medicare+Choice enrollments, including Senior Prime. The MPC generates reports on new Senior Prime enrollments and disenrollments for use by the MCS contractors in their enrollment functions.

As might be expected from the sheer number of systems listed, several data system challenges have been encountered since early in the demonstration. Specific issues are discussed below, in the context of the functions being performed.

EARLY IMPLEMENTATION EXPERIENCES

This section summarizes the stories of how the six demonstration sites prepared for and began operations as Senior Prime plans, and it identifies some of the key events and issues that emerged during those activities. This discussion had to draw parsimoniously from the wealth of information collected during the site visits and interviews with staff at TMA and the HCFA central and regional offices. Refer to the individual site visit reports in Appendix C for additional details. The richness of information was due to the openness of the sites' leadership teams and their commitment to learning from this demonstration. Lessons learned from their experiences and implications for future Senior Prime operations are presented in Chapter 7.

Getting Certified as Senior Prime Plans

The preparations to establish the Senior Prime plans in the six demonstration sites were carried out in a compressed time period, given the short time available from passage of the BBA in late 1997 to the goal for all sites to start service delivery no later than January 1999. Negotiations to revise the MOA to reflect the BBA provisions proceeded through the end of 1997, as TMA began work on the national Senior Prime marketing materials and the Chapter 20 provisions for the MCS contractor roles and responsibilities.

With TMA support, the sites began to prepare the Medicare health plan applications in early 1998. The BBA specified that the sites were to be certified as M+C plans, but HCFA was still developing many of the M+C implementing regulations in early 1998 when the sites needed to begin preparing applications. To allow them to move ahead quickly, they worked under the

rules and forms for Medicare Section 1876 risk-contracting plans, and HCFA provided the M+C rules to TMA and the sites as they became available. These changes in Medicare policy had differing effects on the sites. As shown in Table 1.1, the Madigan AMC, Region 6, and San Diego NMC sites began service delivery in 1998, before Medicare+Choice (M+C) was in effect. All of these sites had to revise and resubmit applications under the new M+C rules, in some cases within weeks before the scheduled HCFA certification site visit. The two sites that were processed for a January 1999 start dates had slightly more time to work with the M+C materials.

During the early period of preparation for Medicare certification, HCFA and TMA retained many of their respective functions and decisions at the national level. The HCFA regional offices entered the process to participate in the final application reviews and certification site visits. HCFA central office performed at least one round of application reviews, with requests to the plans for revisions or additional supporting materials, before bringing in the regional offices. The demonstration sites were instructed by TMA not to communicate directly with HCFA central office or regional offices during this period, which constrained their ability to get the information they needed to prepare acceptable applications. TMA staff and several sites told us that some of the sites sought advice from HCFA regional offices, despite these instructions.

With little in-house Medicare expertise, the sites reported they had difficulties preparing the application. TMA committed financial support for the sites' MCS contractors to hire consultants to provide the needed Medicare knowledge and experience. The consultants turned out to be critically important resources for the sites, helping them prepare the Medicare applications, guiding the plan's design, and training them on the unique aspects of serving an older population. The consultants for some of the sites conducted mock site visits to prepare the Senior Prime teams for the HCFA certification site visits.

HCFA staff in the central office and regional offices reported to us that the final applications from the demonstration sites were of high quality, and HCFA staff participating in the site visits were impressed with the sites' careful preparation, strong organization, and commitment to serving the Medicare-eligible DoD beneficiaries. The application process was the first time that the HCFA and DoD field staff had direct contact with each other, and it provided the start for their working relationships. HCFA staff reported that, with the perspective they gained from these contacts, they gained confidence in the commitment and ability of the DoD sites to perform as Medicare plans, and LA staff at the demonstration sites reported they were pleased with the responsiveness and support of the HCFA regional office staff.

Perhaps the most challenging part of the certification process was the sheer number of Medicare performance requirements that the Senior Prime plans are required to meet in their applications and practice.[20] Accustomed to making their own decisions on MHS policies and practices, TMA and the sites had to adjust to complying with an external party's rules, a process that was complicated by periodic frustration when they felt that some of the rules were unnecessary or not meaningful in the military health system. Negotiations of issues continue

[20] HCFA Central staff informed us that Senior Prime plans share this experience with other new Medicare plans, many of which complain about the amount of work required to become Medicare certified.

today, as the sites identify rules or written forms that do not work well for them in practice. At the same time, the sites are finding that some of the Medicare requirements (e.g., appeals and grievances) are effective tools, and they are applying them to TRICARE Prime operational practices as well. This transfer of practices may be a valuable product of the demonstration, which we plan to monitor as the demonstration progresses.

As Senior Prime moved from the certification process to enrollment and service delivery, the HCFA central office decreased its direct role in the demonstration and shifted the lead for compliance monitoring to the HCFA regional offices. The LA staff for several of the sites visited their HCFA regional offices after their Senior Prime plans became operational, to get better acquainted and provide the HCFA staff with more detailed information on their activities. The HCFA central office and regional office staff coordinate policy and activities through regular conference calls. Wherever possible, HCFA is trying to resolve issues and establish national policy for the Senior Prime plans.

The Enrollment Process

Staff of the sites' LA Office, MTF(s), and MCS contractors worked as teams in conducting the start-up marketing and enrollment process. The MCS contractor provided the administrative support for the activities, hiring temporary staff to handle appointments and schedules for the orientation sessions. The sites all reported that they presented themselves to the beneficiaries as "people who will serve them in Senior Prime," making no distinction between the different organizations. The MCS contractor is responsible for processing enrollment applications and managing all other enrollment materials and activities.

Marketing activities. As soon as each site's contract was executed by HCFA, the site initiated marketing activities for Senior Prime enrollments. Marketing began with advertising through the media that they determined would be effective at reaching the Medicare-eligible DoD beneficiaries, including ads in local newspapers, press releases, public service announcements, notices to elected officials, and communications with local retiree associations:' At least one site used direct mail marketing. Local military retiree associations made important contributions to reaching this population, which is a large share of their memberships, by running articles and notices in their newsletters and otherwise keeping their members informed of Senior Prime.

National marketing materials were prepared by TMA for the sites' use in enrollment, and these materials were reviewed by HCFA and approved as part of the Senior Prime applications. The materials included advertising materials as well as application forms, statement of benefits, and other materials required by HCFA. As HCFA shifted to the M+C rules during Senior Prime start-up, some information in the marketing materials became outdated, and corrections were provided in errata sheets because supplies of the materials had already been printed.

The sites ran intense schedules of orientation meetings for interested beneficiaries that started within a week or two after the marketing began. Groups of 50 to 200 beneficiaries were scheduled for meetings that were held as frequently as twice a day for the first few weeks, with declining frequency in later weeks. Thousands of beneficiaries at the six sites were reached through these sessions. Clinical and administrative staff briefed the attendees on Medicare managed care and TRICARE Senior Prime and answered their questions. Staff were available after the briefing to work individually with beneficiaries as they considered this managed care

option. This was the start of personalized support strategies that the sites had organized to serve their beneficiaries and enrollees.

The sites have reported that an essential element of preparation for Senior Prime enrollment and service delivery was the careful training of the MTFs' front line clinical and support staff, PCM physicians, and specialty physicians. These training activities typically focused on informing providers about Senior Prime rules, techniques for working with older patients, and managing intakes of new enrollees. A series of briefings was held for these staff before marketing and enrollment activities began, and many of the PCM physicians had leadership roles in conducting the beneficiary orientation meetings. The credibility of the physicians at the meetings helped to build trust in the program because attendees knew these physicians would be their primary care providers. This training also helped the staff work with beneficiaries in the clinics because they could answer their questions and refer them to others who could help them.

Other provider training activities also were being performed as the sites identified needs. For example, physicians in all sites have been participating in QM/UM activities and disease management initiatives, and at least one site provided training to physicians on proper coding of diagnoses and procedures on ADS bubble sheets. In the larger medical centers, some work was reported on improving referrals and communications between PCMs and specialty physicians. Based on information the sites provided on early QM/UM activities and plans for managing care, they likely will continue working with providers in these areas.

Given the compressed start-up schedule, some sites had little time for marketing activities. For example, the contract for Keesler AFB was finalized in September 1998, a hurricane hit the Biloxi area at the end of September, they started advertising in early October, and they began beneficiary orientation meetings in mid-October for an early November enrollment application date and start of service delivery in December 1998. Dover AFB was on a similarly tight schedule for a January start of service, and although they did not have to accommodate a hurricane, the LA Office was in the midst of implementing the Region 1 TRICARE program.

Enrollment processing. Madigan/Region 11 was the first site to begin enrollments, and Senior Prime was very much in demand by its beneficiaries. Over 2,900 new enrollees were processed for start of service delivery in September 1998, and the initial screenings and PCM visits for those enrollees almost swamped Madigan's clinic capacity. Learning from this site, staged enrollments were used by Brooke AMC, Wilford Hall MC, Evans ACH, and Keesler MC, anticipating that the level of demand could overload their facilities. The remaining facilities had small enrollments that could be managed more easily, although they still had to manage peaks of activity when service delivery began. Only Madigan, Brooke, and Wilford Hall have reached their planned enrollments. As shown in Chapter 4, enrollments for some facilities have leveled off after the first few months, while those for other facilities have continued to grow at steady rates. All sites are getting age-in enrollments, but the numbers for Dover are small.

Senior Prime enrollments are processed by the sites' MCS contractors. Beneficiaries must mail in their applications to the MCS contractors, which date and enter the applications through the Medicare Processing Center (MPC), an automated data system established by HCFA to process health plan enrollments (including Senior Prime). Each application is verified with

the beneficiary by telephone, including review of the Senior Prime rules for eligibility and service delivery. With the need to verify eligibility for both DoD and Medicare benefits, and to get beneficiaries correctly recorded in the DoD enrollment and claims processing data systems, the contractors' enrollment staff must work with 3 to 4 independent data systems. They enter the application data into the MCP, then work through CHCS to record the beneficiary status in DEERS and, finally, enter the record into the data systems (EAPP or CRIS) of the claims processing subcontractor that will process network provider claims for the beneficiary. Such a system is cumbersome and vulnerable to errors.

Service Delivery

The information on service delivery experiences of the sites offers but a glimpse into the early service needs, and it is not clear from these experiences how service patterns will evolve as the enrollee population stabilizes and as care management practices mature. This is another area we will continue to follow in the evaluation.

MTF Services. PCM clinics at each site were busy in the first few months after Senior Prime began service delivery. Each site and MTF established a distinct strategy for educating their new enrollees, for example, the 5-hour training and screening sessions held by Evans ACH, the Enrollee Education and Health Assessment Strategy (EEHAS) meetings conducted by Keesler MC, and comprehensive rounds of PCM initial clinic visits performed by the remaining sites. These strategies were undertaken to educate enrollees on how to use Senior Prime services, assess health status and identify health problems that needed attention, and prepare for existing health care needs during the transition into Senior Prime.

PCM choices made by new enrollees reminded the sites of the strong preference that older beneficiaries have for internists as their primary care physicians. In some sites, the supplies of internal medicine PCMs were exhausted early, and later enrollees had to be enrolled with family practice or nurse practitioner PCMs. Some of the later enrollees had health problems that were better served by internists, while some early enrollees were healthy and their care could be managed effectively by nurse practitioners. The PCM teams worked with enrollees to change their provider choices, when appropriate, to match provider to enrollee's need and to distribute enrollees more evenly across the available clinics.

The clinic teams relied on nurse coordinators to process and educate new enrollees, and to help coordinate visit appointments. The coordinators, clerks, and other front line staff found they had to spend substantial time with enrollees, responding to demands for instant appointments, coaching them in making the appointment telephone calls, and reinforcing their medical instructions. The Senior Prime enrollees complain a great deal about using "800" numbers or telephone systems with electronic menus. In some regions, the MCS contractors handles TRICARE appointments centrally, including those for Senior Prime. Other sites make appointments locally, which front-line staff report to be the preference of many enrollees.

Early service delivery experiences of the Region 11 and Region 6 sites highlighted the importance of preparing to protect enrollees' ongoing care during their transition to the Senior Prime plan. Services of concern include oxygen and other DME, prescription medications for chronic conditions, and patients undergoing a current course of therapy. Some sites initiated

contact with applicants even as their enrollments were being processed to gather this information, and some sites contacted local DME suppliers to prepare for transitions.

Although the sites' PCM clinics expected the intense workload that occurred as Senior Prime began service delivery, they also had expected a subsequent decline as initial visits were completed and enrollees health care needs were treated. When they discovered the enrollees had a high prevalence of untreated health problems, they realized that service activity could remain elevated longer than they had planned. In addition, peaks of activity in the PCM clinic were being transferred to some of the specialty clinics as patients were referred for treatment of their health problems. Some of the specialty clinics (e.g., dermatology, neurology, pulmonology) experienced increased activity. Ancillary departments also reported increases in service volumes when Senior Prime started, with the exception of pharmacy in some sites, where the older population already had been using the benefit extensively.

Referrals to Network Providers. When enrollees require services not provided by the MTFs, they may be referred to network specialty practitioners or institutional providers, such as hospitals, SNFs, or home care providers. Some sites also referred to other MTFs nearby that were not in the Senior Prime network. For example, enrollees at the Dover site have the option of using one of the large, specialty MTFs in the National Capital area, which is a two-hour drive away. The Region 6 site may refer to other Senior Prime MTFs in the site, other nearby MTFs, or civilian network providers, depending on the enrollees' needs and preferences and the geographic proximity of the providers.

There was limited network provider activity early in the demonstration, with the exception of Dover, which has only primary care in its MTF. In recent months, some sites report that referrals for network provider services have been increasing. Few problems with access or satisfaction have been reported, although the MTF physicians reported that improvements could be made in the communication and transfer of patient records between the PCM and network physicians, to develop a greater sense of professional partnership. Some enrollees at Keesler have complained about long travel distances to network providers, reflecting the site's difficulty in recruiting physicians close to Biloxi (discussed above).

The sites reported few problems thus far with referrals to civilian institutional providers, although some of them stated that they wanted to perform closer oversight and coordination of care for enrollees using those services. Dover AFB is the only site that uses civilian community hospitals because Dover has no inpatient capacity; three hospitals are in Dover's network. Dover physicians have staff privileges at one of these hospitals so they can extend their care for enrollees to the hospital setting and avoid referring to network physicians.

Plan Performance

Quality ***and Utilization Management.*** The demonstration sites' Medicare applications included plans for quality management (QM) and utilization management (UM), which were extensions of the TRICARE Prime plans. All of the sites have established QM and UM teams consisting of the staff responsible for these functions in the LA Office, the MTFs, and the MCS contractor. These teams have met regularly since the inception of Senior Prime, and they report their activities and monitoring results to the quality committee of the plans' governing boards.

Complexity of the financial provisions. The intricacy of the methods for determining Senior Prime payments has confused many participants at the demonstration sites, and the sites tend to be suspicious of how these rules may be affecting their financial performance. Without clear understanding of the financial consequences, the sites find it difficult to discern which management strategies are appropriate. Interactions between the enrollment and service activities.& TRICARE Prime and Senior Prime make it yet more difficult to manage under the Senior Prime financial rules. For example, enrollment growth in Prime may have a strong effect on squeezing out non-enrollee costs for space-available care, which would reduce sites' allowed payments under the LOE thresholds. The only effective way to compensate for that loss due to Prime growth would be to increase Senior Prime enrollments (and associated revenue), which may not be feasible in some markets.

Interim payments, reconciliation, and cash flow to the sites. The sites expressed frustration that they have not received any share of the interim payments made by HCFA for their Senior Prime enrollees, along with doubt that they would ever see any payments. As discussed above, the MTFs bear at least some risk (as does TMA) for enrollee services, and they do so within fixed budgets. TMA has been reluctant to distribute funds from the interim payments because the funds may have to be refunded if the year-end reconciliation determines that DoD has to return payments to HCFA. DoD has not yet released a plan for distributing any payments.

LOE calculation. The LOE is based on FY96 MEPRS data for the participating MTFs. In addition to the complexity of the LOE, several of the sites reported that the FY96 estimates do not represent their most recent baseline LOE accurately because their facilities or services were altered between FY96 and the start of the demonstration. Discrepancies in LOE could hold some downsized sites accountable for past levels of service that would be impossible to meet in their current configurations, in the absence of Senior Prime. Other sites might not be held sufficiently accountable for higher service levels immediately preceding introduction of Senior Prime, although this is less likely than the other scenario because most changes have been downsizing.

Thresholds to determinepayments. In the last few months, the sites have become more aware of the potential financial effects of the threshold limiting the LOE credited for space-available beneficiaries to the minimum of actual costs or a percentage of the LOE. The sites state that (given enrollees' service needs) they have limited flexibility to adjust space-available service utilization, for which they may be penalized financially. Sites are analyzing their service use data to understand the threshold's effects for their operations, and there are concerns about the threshold's potential constraint on financial performance for sites that have low Senior Prime enrollments (but high enough to meet the 30 percent enrollee cost threshold to qualify for payments) and have not experienced much reduction in space-available care for non-enrollees.

Capitation payment adjustments. The exclusion of GME, disproportionate share payments, and a portion of capital costs from the capitation payments is an appropriate adjustment for MTF services because these costs already are included in the MTF budgets. This approach ignores services purchased from network providers, however, and providers with these costs likely have set their fees to cover the costs. This inconsistency has a disproportionate effect on smaller facilities with fewer specialty services that rely upon community providers for those services. The Dover site is particularly affected because much of the inpatient care for its Senior Prime enrollees is provided by network hospitals (although some patients obtain inpatient care from the specialty MTFs in the National Capital Area).

Risk adjustment. The retrospective method that HCFA and DoD will be using to adjust 1999 and 2000 capitation payments for positive or adverse selection in enrollment has the advantage of generating payments that closely mirror expected costs for differing patient mixes. Its disadvantage is that, like other provisions in the payment methods, the sites will not know how risk adjustment will affect them until the end of each fiscal year, again creating uncertainty regarding their financial performance. Although the sites have a qualitative sense of the acuity of their Senior Prime enrollees, they will not be able to verify their assessment until risk adjustment results are reported to them.

Simulation of Payment Method Effects

To test the independent effects of each of several key payment method components on plan financial performance, we simulated Senior Prime payments from HCFA to DoD using a simple model with one plan. We assumed that a total of 6,700 dual-eligible beneficiaries were using space-available services at the MTF before introduction of the Senior Prime plan. We also assumed the MTF had an annual average cost of $3,000 per user for providing their health care services, which is half of a total cost of $6,000 that we estimated using a monthly Medicare capitation rate of $500 (multiplied by 12 months), which represents the expected total costs per month per Medicare beneficiary. This rate falls within the range of Medicare capitation rates for the demonstration sites (Table 4.2), although we note that the Senior Prime rates are lower than these market rates. Thus, the baseline LOE for the MTF was $20,100,000 (6,700 x $3,000), and we assumed that no adjustments were made to this amount per the MOA provision.

When Senior Prime was introduced, some percentage of the MTF's fixed set of users chose to enroll in the plan, and the relative costs of care for the enrollees were some ratio of the baseline costs per user. In the simulations, we varied the percentages of enrollees, the relative costs of enrollees to non-enrollees, and the DoD monthly capitation payment from HCFA to assess the impacts of these factors on DoD payments and financial return.

Net payments to DoD and net return (or cost) are calculated for the simulation according to the payment rules described in Chapter 1, using the first-year LOE thresholds:

1. If total expenses for enrollees and non-enrollees exceeds the LOE --&-the expenses for enrollees exceed 30 percent of the LOE, then DoD may retain payment from HCFA.
2. The allowed cost for non-enrollees is the minimum of actual cost or 70 percent of LOE.
3. The net payment made to DoD =

   gross capitation payments + allowed cost for non-enrollees – baseline LOE.

4. Net return (or cost) = net payment – expenses in excess of LOE.

Scenarios 1 and 2 simulate net payments and financial returns to the Senior Prime plan when the costs of care for enrollees are twice the costs for non-enrollees, or an average annual cost of $6,000 per enrollee. The capitation rate is set at $510 for the first scenario and at $480 in the second scenario, so the plan has revenues higher than enrollees costs in the $510 scenario and lower than enrollee costs in the $480 scenario. For scenarios 3 and 4, we reduced the costs for enrollees to 1.5 times the non-enrollee costs, or an average annual cost of $4,500 per enrollee, with the same capitation rates of $510 and $480. The plan's revenues are higher than enrollee

costs for both of these scenarios. The results of the simulations, shown in Table 5.1, reveal some undesirable incentive conflicts associated with the enrollee/non-enrollee thresholds for percentages of LOE.

Table 5.1
Simulation of Payment Effects for a Hypothetical Senior Prime Plan

	Percentage of Users Who Enrolled in Senior Prime				
	50%	40%	30%	20%	10%
Actual cost for non-enrollees	10,050,000	12,060,000	14,070,000	16,080,000	18,090,000
Allowed cost non-enrollees (min. of 70% LOE, cost) *	10,050,000	12,060,000	14,070,000	14,070,000	14,070,000
Relative cost of enrollee/non-enrollee = 2.0					
Portion of expenses > LOE	10,050,000	8,040,000	6,030,000	4,020,000	2,010,000
1. Monthly capitation = $510					
Gross capitation payments	20,502,000	16,401600	12,301,200	8,200,800	4,100,400
Enrollee costs > 30% LOE?	yes	yes	yes	yes	no
Net payment to DoD	10,542,000	8,361,600	6,27 1,200	2,170,800	0
Net return (cost)	402,000	321,600	241,200	(1,849,200)	(2,010,000)
Return (cost), no 70% LOE	402,000	321,600	241,200	160,800	(2,010,000)
2. *Monthly capitation = $480*					
Gross capitation payments	19,296,000	15,436,800	11,577,600	7,718,400	3,859,200
Enrollee costs > 30% LOE?	yes	yes	yes	yes	no
Net payment to DoD	9,246,000	7,396,800	5,547,600	1,688,400	0
Net return (cost)	(804,000)	(643,200)	(482,400)	(2,33 1,600)	(2,010,000)
Return (cost), no 70% LOE	(804,000)	(643,200)	(482,400)	(321,600)	(2,010,000)
Relative cost of enrollee/non-enrollee = 1.5					
Portion of expenses > LOE	5,025,000	4,020,000	3,015,000	2,010,000	1,005,000
3. *Monthly capitation = $510*					
Gross capitation payments	20,502,000	16,401600	12,301,200	8,200,800	4,100,400
Enrollee costs > 30% LOE?	yes	yes	yes	no	no
Net payment to DoD	10,452,000	8,361,600	6,271,000	0	0
Net return (cost)	5,427,000	4341,600	3256,200	(2,010,000)	(1,005,000)
Return (cost), no 70% LOE	5,427,000	4,341,600	3,256,200	(2,010,000)	(1,005,000)
4. *Monthly capitation = $480*					
Gross capitation payments	19,296,000	15,436,800	11577,600	7,718,400	3,859,200
Enrollee costs > 30% LOE?	yes	yes	yes	no	no
Net payment to DoD	9,246,000	7,396,800	5,547,600	0	0
Net return (cost)	4,221,000	3,376,800	2,532,600	(2,010,000)	(1,005,000)
Return (cost), no 70% LOE	4,221,000	3,376,800	2,532,600	(2,010,000)	(1,005,000)

* Models assume that a total of 6,700 dual eligibles were using space-available care at the MTF before subvention, and that some fraction of those users enrolled in Senior Prime. The annual cost of MTF services for these users was $3,000 per person. Therefore, the historical LOE is $20,100,000 (6,700 x 3,000), and 70% of LOE is $14,070,000.

In our hypothetical model, the effect of the 30 percent LOE threshold for enrollee costs is quite substantial at low enrollment rates, leading to large losses because no payments are made to the plan. This rule creates opposing incentives, where the plan does not want to control enrollee health care costs when enrollment rates are low but wants to reduce enrollee costs at higher enrollment rates. The conflict is shown by the loss of payment at 20 percent enrollment when the relative costs of enrollees is 1.5 but not when the relative costs are 2.0. Yet at enrollment rates of 30 percent or more, net return is much higher when relative costs are 1.5.

We also calculated DoD net payments and net return (or cost) after removing the cap on allowed cost for non-enrollees at 70 percent of the LOE to assess the financial impacts of that requirement. The non-enrollee costs are equal to 70 percent of LOE at the 30 percent enrollment rates. Scenarios 1 and 2 show the large effect of the cap at 20 percent enrollment rate levels, where the allowed cost for non-enrollees is less than 70 percent of LOE. Relaxing this rule improves net return substantially and eliminates discontinuity in financial performance at the non-enrollee cost threshold. The combined effect of the two thresholds (30 percent LOE for enrollees and 70 percent for non-enrollees) creates induced losses for a Senior Prime plan, which is not a desirable incentive.

Another obvious effect that this simple hypothetical model highlights is the importance of the level of the capitation rates relative to the cost of care for enrollees. Where Senior Prime plans are receiving payments for their enrollees, it is essential to manage and monitor medical care costs actively to keep costs within payment rate revenues. It also is important for participants to have confidence that the capitation rates are grounded in reasonable service delivery experience, which they can achieve through responsible management.

For simplicity, we assumed in this model that the cost for non-enrollees remained at $3,000 per year regardless of the percentage of users who enrolled in Senior Prime. We took this approach to pare away some of the complexity of payment methods so that we can observe the independent effects of a few key components – the thresholds, enrollment rates, and capitation rates. There is apparent (reasonable) consensus among demonstration participants that the average cost for non-enrollees should decline because the introduction of Senior Prime enrollees to MTF services increasingly will squeeze them out of space-available care. We can adjust the average cost per non-enrollee downward in this model, at the same time increasing the relative cost of enrollees to non-enrollees to achieve the levels of cost per enrollee used in the scenarios presented here. This shift would decrease payments to the plans, if the threshold for enrollee costs allowed them to receive payments. The first finding from the simulation, however, identifies an incentive for a plan with low enrollment to increase costs of care per enrollee so that total costs reach the enrollee cost threshold and the plan can retain some payments. This issue is independent of the level of costs for non-enrollees using space available care, which contributes to how much payment the plan actually receives.

Financial Strategies of the Sites

In the face of the various financial uncertainties summarized above, and the availability of only limited financial information, the sites have focused initially on making Senior Prime the best possible program for their enrollees. Quality of care, compliance with access standards, and

satisfied enrollees have been their primary yardsticks for success during early operations. This strategy has the advantage of encouraging enrollments (within the constraint of a time-limited demonstration), which will help generate capitation payments. The participating MTFs are being very cautious in increasing their staff, however, because they assume they will get no additional financial support for new staff. Some staff reallocations have been made, especially within the primary care clinics, to provide support to the enrollees as efficiently as possible. Early service delivery costs are reported to have been high, reflecting large numbers of initial PCM office visits and follow-up visits to the PCMs or specialty physicians. Many sites believe that these early operating levels are not sustainable financially.

As service delivery proceeds, the MTFs are beginning to monitor service activity and costs for the Senior Prime enrollees. Many of the MTFs plan to begin detailed analyses after they have 6 to 8 months of service delivery experience. They are waiting to accumulate sufficient service activity to obtain stable estimates of service use and costs. They also want to obtain reasonable estimates of ongoing average costs for enrollees, which are not represented well by the initially high rates of service use by new enrollees during Senior Prime intake and follow-up visits. They are examining where changes in service volumes are occurring, and whether rates of service use are declining after the initial flurry of clinic visits for new enrollees.

We plan to follow the financial activities of the sites during the remainder of the demonstration, particularly seeking to document decisions and actions they take after knowing the results of the first-year reconciliation. Some of the concerns expressed at this early stage of the demonstration may be resolved at that time, and some issues may mature into problems that require closer attention. As we discuss in Chapter 7, the next operational challenge is for the sites to establish priorities for their Senior Prime activities and pursue active management of costs.

EARLY RESPONSES OF BENEFICIARIES TO SENIOR PRIME

Military retirees and dependents have long been seeking initiatives like Senior Prime with the hope of regaining access to the military health care system. There is strong sentiment among this population that the military has broken its promise to provide them health care coverage for life. After a series of military installation closures and introduction of TRICARE, older beneficiaries found they were last in line for MTF services on a space-available basis. As described in Chapter 3, retiree associations have been pushing DoD hard to fulfill that promise, and they have lobbied Congress for legislation to create programs they feel are their due. These associations have supported subvention as one means to improve access to military health care for Medicare-eligible beneficiaries, and some have questioned the need to do a demonstration to test the models before full implementation.

Information about beneficiaries' responses to Senior Prime, and how it has affected them, was obtained from interviews with retiree association representatives, MTF patient representatives, Senior Prime marketing staff, and front line clinical and administrative staff involved in delivering care to Senior Prime enrollees. Although this information did not come directly from the beneficiaries, the various sources interviewed shared what they were hearing, and some consistent themes emerged about beneficiaries' reactions to the demonstration.

After years of seeing changing signals from the government, many older beneficiaries do not trust the government and remain suspicious that the subvention demonstration will be short-lived. Given this history, it is not surprising that responses from dual eligibles ranged from enthusiastic embrasure of Senior Prime to adamant refusal to enroll because it is only a partial response and many of their peers still have no real access to the MHS. The short two-year life of the demonstration was an important reason why people did not join Senior Prime. Many feared they would have to return to Medicare fee-for-service or switch to another Medicare+Choice plan when the demonstration ended, and they could lose their supplemental insurance coverage. Other reasons cited were simply the choices they made among available options. Some beneficiaries' were satisfied with the health care they were getting from fee-for-service civilian providers or VA facilities, and they did not want to change providers. Others were enrolled in Medicare health plans and preferred the benefit coverage they had to what was offered by the Senior Prime plan.

The beneficiaries who chose to enroll in Senior Prime typically did so either because they could return to military health care, or it compared favorably to other choices of Medicare health plans or fee-for-service (or both). Many enrollees retained their Medigap policies to protect themselves against the end of the demonstration. Virtually everyone interviewed reported that enrollees are expressing their satisfaction with Senior Prime services and are very pleased to be back in military health care. The sites' extensive orientation activities and personal approach to support beneficiaries appear to have prepared enrollees well for service delivery. These subjective results are supported thus far by records of few complaints, grievances, and appeals, either filed within the Senior Prime plans or reported directly to HCFA regional offices.

We also heard that Senior Prime enrollees often were confused about how Senior Prime works, what providers they could use, and how to make appointments. Many enrollees have trouble using the electronic appointment systems, and some enrollees who were referred to network providers were unhappy when the providers were not located close to where they live. The front line MTF staff reported they spend a lot of time with enrollees to help. them through these concerns and teach them how to use the system.

DISCUSSION ON SENIOR PRIME EXPERIENCES

Working within demanding time deadlines, all of the participants in the subvention demonstration have achieved a remarkable accomplishment in getting the TRICARE Senior Prime plans designed, certified, and into operation in less than 6 to 9 months. HCFA and DoD invested untold hours of effort in completing the terms of the MOA and providing direction to the demonstration sites as they prepared for Medicare certification. The sites themselves were committed to successful operation of Senior Prime, and they applied their military skills to mobilizing efforts to get it done. Service delivery has been responsive, and efforts are being made to apply care management techniques to avoid unnecessary care.

The early responses of the beneficiaries apparently testify to the success of the Senior Prime plans in delivering services. Although enrollments did not reach the planned levels immediately for some of the sites, their enrollments occurred faster than Medicare enrollment rates often are for private health plans. Many of those who enrolled have expressed to providers and retiree association colleagues their pleasure with their early experiences with the health plan and MTF services. Those who chose not to enroll appeared to have rational reasons for their

decisions, perhaps the most significant one being the short life of the demonstration. We look forward to comparing these qualitative findings with results of the DoD Annual Beneficiary Survey and the GAO survey of dual eligibles in the demonstration sites, which will provide measurable information on the attitudes and experiences of dual-eligible beneficiaries.

One of the difficult issues emerging from the early life of the demonstration is the inadequacy of the financial provisions. The backdrop for these financial issues is the high visibility of Senior Prime within DoD and communication to the sites of a high priority to perform well. The sites reported this priority to be a motivator to do what was necessary to "stand up" Senior Prime effectively and to the satisfaction of their clients – the dual-eligible beneficiaries. Parallel with this message were two financial problems that, thus far, may have discouraged the sites from managing Senior Prime costs as aggressively as their operational and clinical sides: (1) the complexity of the payment methods that makes it difficult for the site staff to understand the effects of payments on their operations, and (2) the absence of assurance that the sites will ever see Senior Prime revenues, even if DoD obtains net payments from HCFA after each year's reconciliation. With the start-up activities behind them, the Senior Prime service delivery activities are moving to an ongoing operational stage, and the sites' management activities will be changing accordingly. We plan to monitor these issues as our process evaluation continues, as well as in our quantitative analyses of utilization patterns and costs for dual eligibles.

POTENTIAL FOR MEDICARE PARTNERS

Even as the Medicare Partners portion of the DoD subvention demonstration was being specified in the MOA, HCFA and DoD did not fully agree on the desirability or feasibility of this subvention model, which allows a Medicare health plan to contract with MTFs to provide specialty and inpatient services for plan enrollees who are DoD beneficiaries. Such a partnership would be feasible only if it offered some gain for both the Medicare plan and the MTF, and thus far, there has been little indication of interest by either party. Disincentives for the site MTFs are created by the MOA financial terms for Medicare Partners, which specify that DoD is required to return all Medicare Partner revenues to HCFA (along with any Senior Prime payments) if the sites do not exceed the aggregate LOE.[21] With the financial performance of Senior Prime still uncertain, some sites indicate they are reluctant to pursue Medicare Partner agreements.

The Medicare health plans serving subvention site markets also have little incentive to contract with MTFs. Dual eligibles enrolled in a Medicare health plan have the right to use MTFs for space-available services. HCFA has been given a legal opinion that, if the health plan paid the MTF for those services, the health plan would be using Medicare funds to pay the DoD, which is prohibited by statute. With no obligation to pay the MTFs for services provided for their Medicare enrollees, local health plans would not be inclined to negotiate an agreement where they would begin to pay for those services. The only scenario we can identify where Medicare health plans might consider contracting is if their enrollees no longer had access to the

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[21] In addition, costs for services provided under Medicare Partners do not count toward the demonstration's total LOE, and Medicare Partners revenues are counted as part of Medicare reimbursement to determine if the maximum reimbursement has been reached each year.

MTF because the combined enrollments of TRICARE Prime and Senior Prime crowded out space-available care for other dual eligibles. In this case, the Medicare plan might be able to obtain lower rates in a contract with the MTF than from a private provider in its network.

Chapter 6

PRELIMINARY COST STUDIES

We need to measure DoD costs of care for Senior Prime members in order to determine whether DoD has met its goals of providing efficient care and not increasing federal expenses due to the Senior Prime program. The DoD uses the Patient Level Cost Allocation (PLCA) method to estimate the costs of services delivered by the MTFs to dual eligibles and to Senior Prime enrollees. This method uses all the easily available military data to estimate costs and so we would like to use this method-or some variation on it-in the evaluation. The PLCA algorithm uses MEPRS data on expenses by category in each MTF and clinical data from SIDR and SADR to allocate the costs in each MTF among patient encounters. The total cost for MTF care to the dual eligibles can then be calculated by summing the costs assigned to each encounter for a patient aged 65 or older.

For inpatient encounters, estimates are made of the average cost of routine services (i.e., excluding ancillary services and clinician salaries) on each unit (e.g. internal medicine, cardiac ICU, etc.) per day of care. The estimate is derived by dividing the average cost of routine services in that ward in a years' time found in MEPRS by the number of patient days in that ward in that year from SIDR records. Similarly, using only patient records in surgical DRGs, the average cost of surgical services (i.e. anesthesiology, operating room, and recovery room) is apportioned in proportion to DRG weight. Similar calculations estimate the average costs of ancillary services per Relative Weighted Product (RWP)[22] for each unit and the average cost of clinician services per Professional Weighted Product (PWP)[23]. For each patient, information about the number of days on each ward, whether surgery occurred, DRG weight, RWP, and PWP is applied to these average costs to estimate the cost of the stay.

This calculation of inpatient cost makes reasonable use of all the easily available data. Nevertheless, it uses many approximations that might (or might not) introduce substantial error. If those over 65 use a higher amount of ancillary and/or surgical resources than a younger person in the same DRG, then the estimate of costs from the existing PLCA will be biased.

Serious biases in the estimate of the relative cost of ancillary services for certain groups of DRGs could affect cost estimates for individual hospitals. (e.g. tertiary care DRGs such as open heart surgery are found in only some hospitals.). These biases could arise even if there is no systematic bias for or against the elderly in within DRG cost estimates. For example, the estimate of patient level surgical costs will be wrong when surgical costs are not directly proportional to DRG weight. So if there is a group of DRGs with a disproportionate number of dual eligibles and a disproportionate amount of DRG total costs spent on surgical resources, it

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[22] RWP is sometimes called weighted cases. It differs from DRG weight only for unusual cases like transfers and outliers which are assigned a weight by inference from the payment rule.

[23] PWP is the ratio of the average CHAMPUS allowed inpatient professional services amount for a given DRG to the average such amount.

would bias the hospital's estimated cost for the care of dual eligibles. Similar conclusions could be drawn about DRGs for which expected ancillary costs vary in proportion to RWP or for outlier cases which may also be concentrated in specific hospitals and for which RWP deliberately underestimates expected cost. We have used California and Medicare discharge data to examine the effect of two approximations on cost estimates and report our preliminary findings here.

DO ELDERLY COST THE SAME AS OTHERS IN SAME DRG WITH SAME LOS?

The PLCA formula assumes that the elderly cost the same as the non-elderly in the same DRG who spend the same amount of time in each ward. This is plausible, because HCFA found that comorbidities accounted for the extra costs of those 70 or older compared to younger persons. But, within many DRGs, older patients have slightly longer LOS than younger patients in the same DRG, so they may have lower costs per day.

The California discharge database describes the hospitalizations of a general population and we have used it to ask whether the PLCA assumption about the similarity of elderly costs is valid or not. Unfortunately, this database does not contain information about the days spent in each ward-only total LOS is available. In the analysis presented here, we assume that the mix of wards used by patients in the same DRG in the same hospital with the same LOS does not depend on whether the patient is elderly.[24] Consequently, we ask whether the costs of elderly persons differ systematically from the costs of the non-elderly who are in the same hospital, the same DRG, and have the same LOS.

For each hospital in our California sample, we regressed charges for its cases on LOS, DRG dummies, the interaction of these DRG dummies with LOS, and an indicator of whether the patient was age 65 or older. The coefficients on the elderly dummy are summarized in Table 6.1. In the typical hospital in California, charges for an elderly case are $905 less than charges for a non-elderly case in the same DRG with the same LOS and amount equal to 5.4% of the charges for the case. Charges were less for the elderly than for similar non-elderly in 83 percent of the hospitals providing care to 89 % of California's seniors.

Table 6.1
Coeffkients on Dummy Variable for Patients 65 or Older in Hospital Specific Regressions of Patient Charges on DRG Dummies and LOS Within Each DRG

	Hospital weighted	Elderly case weighted
Mean value	-905	**-845**
Mean percent of average charges	**-5.4%**	**-4.4%**
Percent negative	**82.6%**	**88.7%**

Note: Based on 374 separate regressions

[24] This could be tested with existing military inpatient data.

The amount of the difference between similar elderly and non-elderly patients varies by DRG. In analyses restricted to large hospitals, we found that when we added an interaction between the Major Diagnostic Category (MDC) and the elderly dummy it was almost always highly statistically significant. There was no significant interaction between the elderly dummy and whether the case was surgical.[25]

Table 6.2 shows the average value of the coefficient on elderly when separate regressions where run for each combination of MDC and hospital. There is a wide variation across MDCs in the dollar amount of the difference in charges between similar elderly and non-elderly patients and in the percent of typical case charges represented by that difference.

Table 6.2

Coefficients on dummy variable for patients 65 or older in MDC and hospital specific regressions of patient charges on DRG dummies and LOS within each DRG

	Hospital Weighted		Elderly Case Weighted		
MDC	Mean Coeff.	% of charges	Mean Coeff.	% of charges	N of elderly cases
1	-971	-7.3%	-1499	-9.6%	76343
2	-196	-2.2%	-418	-3.9%	1216
3	-425	-4.9%	-699	-7.2%	5885
4	-685	-4.2%	-868	-4.9%	130022
5	-851	-5.3%	-1078	4.8%	247965
6	-341	-2.4%	-412	-2.6%	90172
7	-47	-0.3%	-245	-1.4%	26841
8	-828	-5.0%	-1411	-7.5%	91302
9	-805	-7.6%	-1033	-8.8%	18634
10	-694	-7.5%	-917	-9.0%	28682
11	-522	-4.3%	-644	-4.5%	39135
12	-239	-2.0%	-362	-2.9%	14869
13	-153	-1.3%	-125	-1.0%	12973
16	-192	-1.6%	-369	-2.9%	7173
17	-945	4.9%	-1667	-7.7%	12980
18	-1125	-5.9%	-1574	-7.3%	27381
19	-81	-0.8%	514	3.3%	15333
20	-386	-5.0%	40	0.5%	1820
21	-922	-8.9%	-1202	-10.0%	6842
22	-11	-0.1%	1832	4.5%	317
23	-45	-0.5%	-259	-2.6%	2356
24	-149	-0.4%	1429	2.8%	914
25	-898	-3.3%	-4507	-16.7%	151
None	-268	0.3%	-1393	-1.4%	10435

[25] The interaction of surgical and elderly was tested both within and across MDCs.

Indeed elderly psychiatric patients (MDC 19) actually cost more than non-elderly patients in the same DRG and LOS. With a smaller dollar amount, so do substance abuse patients (MDC 20) and those in two of the smaller MDCs (MDC 22, bums, and MDC 24, major multiple trauma).' Excluding MDCs with fewer than 1000 elderly cases the difference in costs ranges from 3.3% higher to 10% lower with many large MDCs found to have large negative coefficients.

Are surgical costs proportional to DRG weight?

In order to investigate this issue, we apportioned total surgical cost for Medicare patients at each hospital among Medicare patients in proportion to their DRG weight. We also calculated the surgical cost of the patient by multiplying patient charges for surgery (including anesthesia, operating room, recovery room, and labor and delivery) by the appropriate ratios of cost to charges. Then we averaged the surgical costs incurred by the patients in each DRG and calculated the error in the PLCA estimate as the PLCA estimate of surgical costs minus the average surgical cost estimated by the ratio of Cost to Charges.

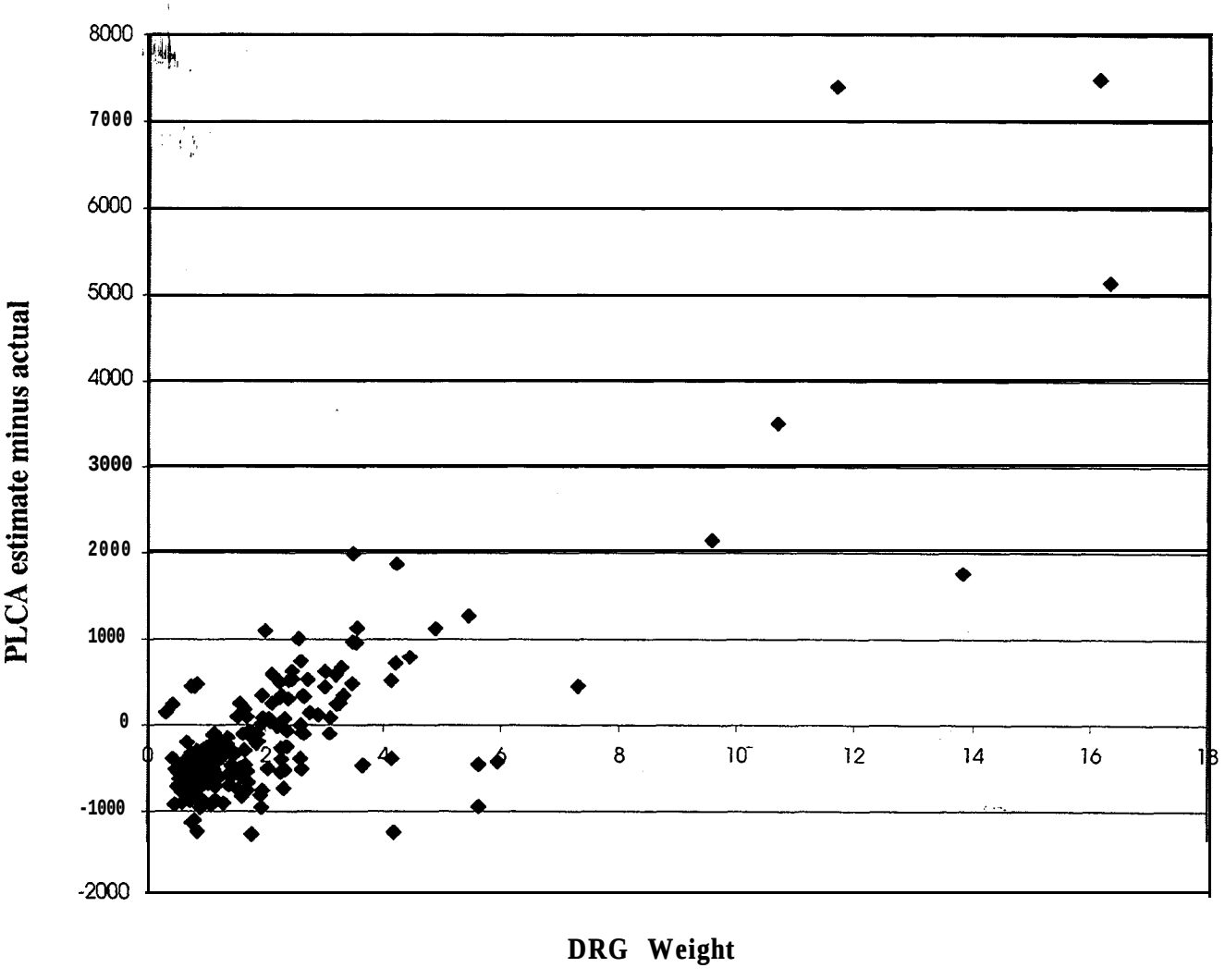
Figure 6.1 plots the difference between the estimate and the DRG weight. There is a strong correlation between the magnitude of the difference and the DRG weight. (Pearson correlation coefficient = 0.81). In general surgical costs for DRGs with relatively low weight are under-estimated and surgical costs for high weight DRGs are over-estimated. Many of the higher cost surgical DRGs have high costs for routine'care, ICU care, and other ancillaries and thus their surgical costs are being over-estimated. The few very high weight DRGs have a disproportionate effect on the computed correlation coefficient, but if the 5 highest weight DRGs are dropped, the correlation remains at a quite high value of 0.60.

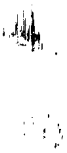
NO CONCLUSIONS YET

We expect that the cost of inpatient care for dual eligibles is overestimated because the formula assumes that the cost per day in the same ward for the same DRG does not depend on age. In fact elderly patients cost about the same amount per case, but have somewhat longer LOS, and somewhat smaller average daily costs. However the amount of this overestimate may be quite modest. We find that the bias amount varies by MDC, ranging between elderly costs being 3.3 % higher than similar non-elderly in psychiatric DRGs to 10% lower costs in MDC 21 (Injuries). In the future, we plan to estimate the amount of the bias in elderly costs at each demonstration MTF. We need to obtain the distribution of elderly cases by MDC at each site and that is not now available.

Although the total overestimate may be modest, the fact that surgical costs are overestimated in high weight DRGs may increase the overestimate of the cost of dual eligibles at certain facilities to higher levels. If elderly patients are concentrated in more expensive surgeries, than the overestimate will be worse at tertiary care facilities than at community hospitals. We need the distribution of elderly and non-elderly cases by DRG at each facility to obtain a rough estimate.

Figure 6.1 Difference in PLCA estimate of surgical cost versus DRG weight





Chapter 7

IMPLICATIONS AND ISSUES FOR A BROADER SENIOR PRIME PROGRAM

When considering policy for a government program, the nature of the public welfare responsibility vested in the government entities involved should be guiding deliberations. For the subvention demonstration, and any permanent subvention programs that may emerge from it, the public welfare mission may be viewed as sustaining the welfare of Medicare-eligible DoD beneficiaries through responsible use of public funds. As discussed in Chapter 3, HCFA and the DoD share the commitment to these beneficiaries, and the subvention demonstration is testing two models to enhance their health care benefit choices.

With Medicare-eligible beneficiaries projected to be an expanding share of the DoD beneficiary population in the future, DoD is evaluating options to provide for their supplemental health coverage needs. Senior Prime and Medicare Partners are but two alternatives that might be appropriate for the older population, and several others are being explored by the Congress and DoD.[26] DoD recognizes that several options will be needed to respond to differing beneficiary preferences and to the variety of circumstances in local markets. Even if Senior Prime was offered in all MTF catchment areas, many beneficiaries living outside the catchment areas would never have access to this option, and some living within the areas would not find it attractive. The discussion in this Chapter acknowledges this larger perspective, while focusing on considerations regarding Senior Prime as an option, given what has been learned from the demonstration to date. With no Medicare Partners activity, no assessment can be made yet.

The possibility of permanent introduction of Medicare subvention (or other model) to the MHS impels consideration of a basic policy issue for the Congress and DoD. ***What is the health care mission of the military health system and how does serving the older DoD beneficiaries, and therefore subvention, fit into that mission***? As we discuss in this chapter, there are tensions and tradeoffs between the MHS medical readiness mission and DoD's obligations to Senior Prime enrollees, and the sites have reported that substantial resources are required to initiate and operate Senior Prime plans. Unless budgets increase, these resources of necessity are taken from other medical readiness or peacetime health care activities. If the Congress and DoD determine that serving this population is an important part of the DoD health care mission, after taking into consideration operational and financial lessons from this demonstration, then appropriate resources can be committed and financial tradeoffs made.

In examining Senior Prime issues and options, our focus is on the DoD health system because that is where Senior Prime implementation takes place. Because Senior Prime plans are

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[26] Two examples are the demonstrations testing FEHBP and a TRICARE Senior Supplement as supplemental policies for Medicare-eligible DoD beneficiaries.

under contract to HCFA as Medicare+Choice plans, they must comply with the Medicare+Choice rules set forth in statute and regulations, and HCFA and DoD together forge the provisions that are unique to the military health system and environment. We point out in our discussion where shared decisions are required by HCFA and DoD, and we highlight the value of the balance that can emerge from careful negotiations.

The TRICARE Senior Prime demonstration still is in an early stage of operation, and we anticipate that new issues will arise and other issues be refined as the demonstration continues. Yet the early experiences of HCFA, TMA and the demonstration sites already can instruct us on some of Senior Prime's successes and challenges and implications for the future. In this chapter, we discuss two categories of initial findings and issues: (1) policy issues that Congress, HCFA and DoD will need to address if Senior Prime becomes a permanent program in the ME-IS, and (2) lessons learned regarding how to strengthen program implementation.

POLICY ISSUES FOR PROGRAM DESIGN

Balancing Interactions Between the Readiness Mission and Senior Prime

All of the Services' medical departments have a go to war mission and must be poised to support a major theater war (MTW). Further, with the Gulf War, the military has made a commitment to maintain peacetime beneficiary care while undertaking a major theater war. In addition, military medical personnel and units have other operational demands that they must be prepared to meet including contingency operations and ongoing training missions. One of the issues this demonstration is highlighting is the need to address how MTFs can balance the demands of peacetime care, training, and contingency operations if Senior Prime becomes a permanent part of peacetime care.

With recent changes in the National Military Strategy and the downsizing of the U.S. military, the Military Health System (MHS) has become more and more focused on the readiness mission. The operational tempo of U.S. forces, including combat service support units, has increased since the end of the post-Cold War. This increase in contingency operations includes a reliance on military medical assets to provide support to combat forces engaged in a wide range of military operations from peacekeeping and humanitarian missions to noncombatant evacuation operations, among other types of contingency operations.

Contingency operations such as Kosovo, Bosnia, Haiti, or Somalia have seen the recent deployment of medical assets and personnel from all three military services to a number of regions of the world, at times in support of joint medical missions. For example, all three Services have jointly shared the medical mission in support of peacekeeping forces in the Balkans region. Evans Army Community Hospital had approximately 20 of its medical staff deploy to the Balkans as part of the 10th Combat Support Hospital (CSH) during the start-up of Senior Prime. The USAF Academy also had one of its four internists who serves as a primary care manager for Senior Prime deploy to Saudi Arabia for 4 months during the same time period. Unlike routine training missions, contingency operations are unpredictable and are not currently planned for.

For contingency operations, military medical units are task organized and cross-leveled to support deploying maneuver units that at times may not be part of the post. For example, both

Brooke Army Medical Center and Evans Army Community Hospital recently saw the deployment of medical personnel in support of troops from Fort Hood. So while a military treatment facility may lose medical personnel to a deployment, the troop population using the military treatment facility may remain at the same level. Further, contingency operations may equally impact primary and specialty care given the very nature of how the military medical system is designed; i.e., specialists may deploy in more generalist roles.

In addition, military medical units have ongoing training missions whether it be to undertake training exercises in preparation for specific types of operations or to support the routine training of units. Two of the military treatment facilities in the Senior Prime demonstration are Forces Command (FORSCOM) installations (Madigan AMC at Fort Lewis and Evans ACH at Fort Carson) and support large deploying, active-duty troop populations. When their maneuver units go into the field for training they take the PROFIS medical personnel assigned to the units to provide medical support to combat troops. Essentially, the military treatment facility loses these medical personnel for the 2-3 weeks duration.

The current system for providing medical personnel for deployments is somewhat similar across the three Services.. For example, Air Force medical personnel have specific mobility assignments that can be activated in support of a contingency operation. Indeed, in recent years the Air Force has actively sought such assignments. Air Force deployable medical capabilities range from four-person Critical Care Air Transport teams that can provide intensive care to patients being transported, to air transportable hospitals that provide hospitalization care for peacekeeping or other types of contingency operations. The Navy too has deployable medical platforms that include medical battalions and surgical companies, fleet hospitals, casualty receiving and treatment ships, and several large hospital ships, among other capabilities. Navy Medical Augmentation Teams (MAT) personnel are assigned a billet and provide an augmentation package in support of such platforms when they are deployed. The Navy also provides medical support for the Marines. Army medical personnel designated as Professional Filler System (PROFIS) are assigned to deployable military medical units such as. forward surgical teams, combat support hospitals, among others. For all three Services, military medical personnel provide peacetime care in fixed facilities when not deployed or conducting routine training missions.

All three Services also have Graduate Medical Education (GME) programs. In this demonstration, four of the sites have ongoing GME training programs in a variety of specialty and subspecialty areas. As the military health system moves increasingly towards population-based medicine (treating young healthy troop populations and their families), it will need to address how elderly, more complex patients (such as Senior Prime enrollees) may contribute to military physicians maintaining their clinical skills.

How does all this tie in with TRICARE Senior Prime? With respect to the readiness mission, there are three main areas of concern: recruitment and retention, training and sustainment of clinical wartime skills, and ability to deploy. We discuss the relationship between readiness and TRICARE Senior Prime in each of these areas and then offer some observations and recommendations regarding policy options for addressing the intersection between the two.

Recruitment and Retention. Historically, serving the senior population has been viewed by the three Services as having made a positive contribution to recruitment and retention of

military physicians. Military physicians like treating this population because they have complex health care needs that allow the physicians to use their clinical skills fully. The readiness contribution of the senior population may be especially useful for Air Force MTFs, the majority of which are small clinics in relatively remote areas. Many of the Air Force physicians assigned to these clinics are young and fresh out of their medical training, and they want to practice a full scope of medicine to reinforce their new skills. Therefore, having access to the Senior Prime population at an outpatient clinic such as at Dover Air Force Base may serve as an important retention tool. The Army and Navy also have cited the elderly population as being important to their recruitment and retention of military physicians. However, it may be less important to have Senior Prime at Army and Navy MTFs with only outpatient services, because both services have a mix of large medical centers, smaller community hospitals, and outpatient clinics through which their physicians rotate.

Training and Sustainment of Wartime Clinical Skills. The elderly population also has been cited by all three Services as being important to their training programs and for graduate medical education, although the three Services have differed in the degree of emphasis placed on GME. Overall, GME can be viewed as a requirements-based system intended not only to tram military physicians, but also to serve as a recruitment and retention tool. For some subspecialty programs, a large patient population of elderly beneficiaries has been viewed by the sites as being essential for sustaining their training programs. This point is underscored by the fact that, before Senior Prime began, many of the demonstration sites already had impaneled a group of seniors or were providing care to military retirees on a space available basis. In our site visits, both primary care and specialty physicians from all three Services asserted the importance of the elderly population in terms of enabling them to maintain their clinical skills. MTFs have been losing this patient base, however, with declining space-available care.

Ability to Deploy. On the negative side, the establishment of a contractual obligation to serve the Senior Prime population, including compliance with access standards and other requirements, may compete with the MTFs' mission to deploy military medical personnel when needed. We have seen some discordance between how medical units are task organized for contingency operations and the peacetime medical mission of the facility-a discordance that does not necessarily allow for a coherent medical care plan to be made for an entire community. For example, the deployment of medical units to support units that are not part of the MTF's base population may result in losses of medical personnel without accompanying reduction in the size of the base population. Maintaining such flexibility has become more of an issue with the loss of redundancy as the medical force has been downsized.

Among the demonstration sites, some facilities have experienced the effects of deployment more than others. The timing of the startup of delivery of services for Senior Prime patients at this site coincided with the deployment of both Army and Air Force medical personnel.

Policy Options. Military retirees have demonstrated a strong loyalty to the Services and many currently enrolled in the Senior Prime Program recognize that the job of the military physician may require them to deploy now and then. Several policy options are being explored by the demonstration sites (and others) to help manage the potential conflict between deployments in fulfillment of the readiness mission and obligations to Senior Prime enrollees:

1. *Maintain flexibility in the system.* Mechanisms are needed that can respond to the unpredictable and rapid pace demands of contingency operations, but the temporary nature of deployments makes it difficult to find good options for achieving this. Further, with recent reductions in the size of the medical force, much of the redundancy in the system that would allow for this kind of flexibility no longer exists. A number of the options proposed all share problems of higher costs than MTF care and a limited ability to respond quickly to changing demands. Available options, include:

   - Referral of Senior Prime enrollees to civilian networks.
   - Use of reservists to backfill MTFs that have lost deployed medical personnel.
   - Cross-leveling of personnel from other MTFs to support the deployment of military medical personnel from another facility.
   - Resource sharing agreements to utilize civilian providers where savings are shared between the managed care support contractor."
   - Resource support where the MTF pays for requested services up front.

   The last two options, by their very definition, share several problems. Many civilian physicians are unwilling to participate for such short periods of time and on such an unpredictable basis. It also takes time to identify candidate providers, negotiate agreements, and get physicians credentialed and familiar enough with the MTF and its policies and procedures to be useful. Further, in markets where physicians are in high demand, or where civilian providers may view managed care negatively, it can be difficult to identify such civilian personnel within an adequate amount of time to be beneficial to the MTF.

2. *Ensure the correct mix **of skills.*** It is too early to determine whether the mix of clinical skills needed for sustainment training matches the set of skills required to provide care to Senior Prime patients. This question deserves careful consideration as more experience is accumulated with changing types of deployments and with Senior Prime, especially if this program becomes a permanent part of the MHS. We might see a divergence occurring between the skills necessary for the wartime mission and for peacetime care for the elderly. For example, the clinical skills necessary to treat chronic medical conditions in the elderly do not necessarily contribute to the overall readiness mission. Thus, it may be better for Senior Prime plans to outsource some specialties (e.g. geriatric pharmacist) than to expect participating MTFs to provide them.

Structuring and Managing Senior Prime Effectively

We draw upon the early experiences of the six demonstration sites to begin to explore options for organizational structure and participant roles under a broader Senior Prime program.

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[27] In ***resource*** sharing, the MCS contractor provides staffing, supplies or other resources that allow work to be done in the MTF. The contractor gets credit for the workload, and savings are shared between the government and contractor during bid price adjustment. In ***resource support,*** the MCS contractor provides staff for cost plus a management fee, serving as a form of contracting officer with less federal contracting burdens. The MTF pays for requested services as they are provided.

This discussion is intended to provide some considerations and organizational approaches for policy decisions by HCFA and DoD. We will continue to develop these concepts as additional information is accumulated from the evaluation. We explore here design options for selection of markets and participating MTFs, governance and management structure, and strategy for phasing in a larger program.

Selection of markets and MTFs. The configuration of Senior Prime plans chosen for a larger system, and the MTFs that participate in them, will define the system's profile of enrollees, service delivery, and financial performance. Therefore, it is important for the policy aims for such a system to be clear to ensure that the aims guide system design decisions. Per the discussion in Chapter 3, the DoD goals are to improve access to the DoD health system for dual eligibles, maintain budget neutrality, and strengthen managed care skills in TRICARE. The budget neutrality goal allows some flexibility to include a mix of profitable and unprofitable sites if some of the sites contribute to other goals, such as the readiness mission. HCFA's goals also must be considered, as another major participant in subvention. For example, an unprofitable Senior Prime plan would harm HCFA's goals for beneficiary protections and plan performance if services to enrollees began to deteriorate or the plan terminated operation. Therefore, HCFA would be expected to share with DoD a desire for the sites to succeed, within the constraint of protecting the Medicare trust fund.

In this context, we take a business orientation from the DoD perspective in our initial consideration of the factors and tradeoffs involved in selecting MTFs as providers in Senior Prime plans, looking for (1) the ability to serve a good size dual eligible population, (2) the potential for financial viability, and (2) a contribution to the DoD readiness mission. The characteristics of both the MTFs and the markets in which they are located will contribute to those factors. Table 7.1 summarizes the characteristics and related considerations that we have identified. The first step in analyzing the MTF options would be collection and analysis of data on these characteristics for MTFs in the MHS.

The early results of our process evaluation indicate that medical centers or community hospitals with a balanced mix of primary care and specialty care were able to move into Senior Prime most easily and quickly. Larger medical centers with the depth of clinical specialty capability to serve most health care needs may save money by avoiding referrals to network providers (if their costs are lower than the prices paid to network providers), but unless they already have an experienced PCM function under TRICARE Prime, they may have more trouble gearing up for Senior Prime than other facilities.

Table 7.1
MTF and Market Characteristics to Consider in Selecting Senior Prime Plans

Characteristics	Considerations
Military Treatment Facility	
• Mix of' primary and specialty care	Balance of active primary care with a mix of specialties is positive for Senior Prime success.
• Inpatient and specialty service capability	Presence of inpatient and specialty mix limits the amount of care that must go to network providers
• Production efficiency	Comparisons of MTF unit costs of care to capitation rates can identify potential financial performers.
• Readiness and deployment	Readiness may be sole Senior Prime value for small outpatient MTFs; for MTFs with heavy deployments, Senior Prime services may suffer.
• Medical education programs	Care for Senior Prime enrollees strengthens medical education programs and contributes to readiness.
Local Market	
• Supply of community providers	It is easier to recruit network providers in communities with a rich provider supply.
• Size of eligible population	Larger dual-eligible populations offer potential for large enrollments; also economies of scale.
• Presence of managed care	In managed care markets, both enrollees and providers understand managed care and are more willing to participate in Senior Prime
• Medicare capitation rates	Capitation rates are the plan revenues, and higher revenues are desirable for financial performance.

A potentially challenging policy tradeoff for MTF selection is raised by the early experience of the Dover APB demonstration site. The Dover site reports that it is losing money on Senior Prime, yet the clinicians at Dover tell us that Senior Prime is becoming important to their readiness mission by helping to retain physicians and keep their clinical skills honed. What are the retention gains? How much is the readiness role of Senior Prime worth to the DoD? Under what circumstances might losses on Senior Prime for smaller MTFs offer a payback in savings in the readiness mission? Another consideration in this example is the Service of the MTF. Most of the Air Force MTFs are clinics like Dover, unlike the Army and Navy that also have large MTFs that can support physicians skills. Perhaps it would be appropriate to include Air Force MTFs like Dover in an expanded system, but to exclude Army or Navy facilities that provide only outpatient services.

It would be useful to assess which factors are contributing to Dover's reported losses, and their relative contributions. Some factors can be assessed in the evaluation cost analysis, which we plan to undertake. An understanding of those factors is necessary to assess how Dover's experience might generalize to MTFs of similar characteristics. It is likely that a low capitation

Given these findings, it would be appropriate to re-evaluate the payment system for Senior Prime to seek a design that can (1) reduce uncertainties for the sites regarding their potential financial performance and the consequences for them and (2) align the sites' incentives so they can focus on providing quality care to their enrollees and managing the costs involved in doing so. Any modifications to the payment methods would be guided by the basic financial principles laid out by HCFA and DoD for the MOA (see Chapter 3) to protect the Medicare trust fund and maintain budget neutrality for the DoD. The establishment of the following conditions in a modified payment system would help achieve these goals:

- Provision of timely information on the methods and timing for distributing revenues to the LA Offices and MTFs, so that local commanders will have assurance of the receipt of funds (or not) and can plan for use of the resources for service delivery for enrollees.
- Absence of conflicting financial incentives regarding service provision for Senior Prime enrollees, non-enrollees who use space-available care, or other DoD beneficiaries.
- Simplicity in the payment methods so that both the methods and their consequences for site payments can. be readily understood by participants.
- Confidence by the sites that the historic LOE accurately reflects appropriate baseline spending so the sites do not feel they are being penalized for over-estimates or incorrectly assisted by under-estimates.
- Confidence by the sites that payment rates reasonably reflect the sites' expected costs of care for enrollees, including those incurred by network providers and charged to the plan.

Achieving Effective Clinical and Cost Performance

The sites appear to have achieved impressive early results in delivering care to Senior Prime enrollees, for which they have been rewarded by expressions of satisfaction from their enrollees. It is too early, however, to tell how cost effective the program will be: To achieve and maintain budget neutrality, actions are needed in several aspects of the management of health care delivery and costs. Several key issues emerged from our site visits and interviews with TMA staff that merit attention, both to enhance Senior Prime performance for the remaining life of the demonstration and for a future systemwide program.

Cost effective clinical care. The comprehensive management of the quality and costs of care for Senior Prime enrollees involves the following functions, which also are relevant for management of care for TRICARE Prime enrollees:

- Integration of consistent performance standards into health care delivery processes for key health conditions across the MTFs;
- Proactive case management for enrollees with chronic health conditions, multiple morbidities, or episodes of severe or costly illness;
- Focused pre-authorization and review activities to improve service components that have been identified as problem areas for inappropriate utilization; and
- Consistent quality and utilization monitoring across the Senior Prime sites (or programs in the future) with feedback reported regularly to providers.

After completing the Senior Prime start-up and enrollment activities, the sites now are focusing their efforts on many of these elements. The sites are taking the reasonable approach of working together to build one QM plan with a consistent set of performance standards and indicators that all Senior Primes will use to monitor progress and compare plans' performance to demonstration-wide benchmarks. Yet they have been constrained in these efforts by problems with the availability and quality of needed data, as well as by conflicting measurement standards among multiple quality and utilization management initiatives across the DoD.

The sites are working independently on their UM plans and activities, and they are focusing efforts to varying degrees in two areas: implementation of case management techniques to proactively manage the complex health problems of the older enrollee population, and selective pre-authorization procedures that focus on services where this function will be most likely to reduce inappropriate utilization. The UM and case management roles are being performed by MTF staff in some regions, and by MCS contractor staff in other regions, as determined by the Chapter 20 Senior Prime provisions and the terms in the MCS contracts. In some cases, the contract terms appear to be restricting the ability of MTF and contractor staff to perform focused pre-authorizations and to design the flexible, creative case management and disease management approaches they desire. Contract revisions would be required to address this problem.

Both short-term and long-term challenges exist in this area. In the short term (for the remainder of the demonstration), the sites face the challenge to manage care proactively to ensure that MTFs are providing Senior Prime enrollees appropriate and efficient (i.e., cost effective) care. In the longer term, to prepare for a systemwide program, the DoD should continue its efforts to establish consistent practice standards that all MTFs may use, and it should explore ways to provide for greater UM flexibility into MCS contracts. The DoD data system capabilities also need to be built to generate timely and actionable information for the MTFs' QM/UM activities and for DoD use to monitor the cost effectiveness of care in its facilities.

Administrative costs. Careful assessment is merited for two distinct aspects of the administrative costs that have been incurred during the demonstration. First, the resources invested by the LA Offices, MTFs, and MSC contractors to make Senior Prime operational may have been disproportionately large, when compared to the size of their dual eligible populations (in absolute numbers and as a share of the total beneficiary populations). The sites have taken justifiable pride in "doing the job well," but they also are questioning whether such an investment is appropriate. They cite opportunity costs that have been incurred in the non-performance of other projects, tasks, or initiatives that also are important for patient care or MTF management. On the other hand, HCFA regional office staff reported to us that mobilization of resources of this magnitude is typical of start-up Medicare health plans, to help new enrollees learn the health plan and ensure that their health needs are being properly managed. In addition, the Senior Prime plans are quite small plans, when compared to other Medicare plans that can spread their start-up and overhead costs over much larger enrollments.

The rigor of the Medicare certification requirements is one factor driving administrative costs, and other contributing factors included the speed of the demonstration start-up and the shifting Medicare rules as the new M+C program was implemented and HCFA introduced the new regulations to the demonstration sites. The sites believe that administrative costs will remain high as they fulfill Medicare compliance requirements and related tasks, although we

expect there should be some decline over time as the sites become more proficient working with the program, even with compliance demands. If Senior Prime becomes an ongoing part of the TRICARE program, then appropriate investment in the organization and management of the plans is essential to ensuring their long-term effectiveness. The question is "how to do this as efficiently as possible?'

RAND's evaluation will be examining the cost impacts of the demonstration, which will include some estimates of the administrative costs. Administrative costs will be compared to the overall service delivery costs and financial performance, and as well as to those of other Medicare managed care plans of similar size. Estimates will be generated of possible changes in administrative costs as plans gain operating experience and for larger plans that would include multiple participating MTFs. Additional assessments by TMA and the demonstration sites also are suggested, to obtain estimates that reflect operational details that they can identify best.

The following additional actions are suggested:

- TMA and the sites should work with HCFA central and regional offices to explore possible areas where procedures can be streamlined to reduce both start-up and long-term administrative costs. These interactions can be used as a vehicle to help HCFA staff become more familiar with the military health system and TRICARE Senior Prime.
- Improve the efficiency of new start-ups by building upon the expertise, systems, and procedures that have been developed by the sites during the demonstration;
- Provide reasonable time for new sites to prepare for HCFA certification and the start-up of Senior Prime enrollment and service delivery;
- Involve participants at both the national-level (HCFA Central and TMA) and regional and local level (HCFA regional offices, LAs, MTFs, MCS contractors) early in the planning for an expanded program and throughout the plan certification process.
- Maintain close communications between the sites and HCFA regional offices for efficient processing of materials, plans, and other documents during the certification process.
- Wherever possible, provide mechanisms for systemwide HCFA approvals for plans, materials, and activities to avoid duplication of efforts.

The second aspect of administrative costs that we explored is the increase in MCS contractor costs incurred to support the Senior Prime demonstration, and uncertainty regarding the extent to which those costs may continue under an ongoing program. Some of the personnel costs incurred by the contractors were for temporary staff to support the high volume of initial enrollments, which were eliminated after enrollment rates subsided. Other one-time costs were incurred for participation of MCS contractors in planning for the demonstration and development of Chapter 20 provisions. Some portion of the new contractor costs will continue because they have hired additional BSRs, HCFs, and other staff to handle ongoing enrollee appointments and referrals, as well as provider network management. Recognizing the many program uncertainties, TMA is paying the contractors on a cost-plus basis for the demonstration, and payments have been delayed until costs can be accounted properly and billed. Delaying contractor payments will increase TMA costs because contractors will factor their costs for funding cash flow into their billings to TMA. As it becomes possible to specify clearly the set of

tasks that MCS contractors are to perform under Senior Prime, a priority should be placed on defining a fixed-price contract, to be applied for the remainder of the demonstration and in a permanent program.

Core Medicare expertise in DoD. Perhaps one of the most important impediments during start-up of Senior Prime at the demonstration sites was the limited amount of Medicare expertise within the DoD system. Virtually all the staff in the sites' LA Offices and MTFs were learning the Medicare managed care rules as they were organizing the Senior Prime plans. This learning curve added to the staff time required for start-up, although this barrier should decrease as a core of expertise develops within DoD. The Medicare consultants that TMA funded were an important resource, with the sites reporting that they relied on them heavily. For a larger system, TMA should consider assembling a team of military and civilian staff with Medicare knowledge and experience to help plan the new system, train personnel at participating sites, and serve as a technical resource during start-up and ongoing operation:

- Draw upon the knowledge and experience of the LA and MTF staff in the demonstration sites as a core for such a team.
- Establish a system for regular training of new military personnel as rotations occur.
- Place civilian employees with Medicare knowledge in selected key positions to provide stability as military personnel are re-assigned.
- Locate members of the expert team in both the TMA office and the regional LA Offices to ensure they become working partners with the sites' staff.
- Use temporary exchanges of personnel between HCFA and DoD to build skills and knowledge within both organizations on how the other organization operates.

Cost effective network of civilian providers. The mix and locations of providers in the Senior Prime network affect both enrollee satisfaction with their health care and the costs of providing that care. Demonstration sites have encountered few problems in recruiting new institutional providers, but some sites have had difficulties finding sub-specialty physicians who are willing to contract with Senior Prime. The following strategies are suggested to strengthen linkages with community providers:

- For sites served by MTFs with limited inpatient or sub-specialty capabilities, analyze the costs of services for network providers relative to what it would cost the MTF (or other similar MTFs with the service) to provide the service. Using this information, explore strategies to attain the full mix of providers at reasonable costs, comparing costs for network providers, resource sharing for civilian physicians, MTF circuit riding by military sub-specialty physicians, or cooperative agreements with community clinics or hospitals.
- To reduce civilian provider resistance to military contracts, seek out some providers to learn their views and concerns. Develop a strategy to respond to those concerns, for example payment premiums or providing better medical chart documentation when patients are referred. The concerns of community physicians about low rate structures can be assessed by comparing the CMAC rates and Medicare Fee Schedule rates for high volume procedures.

- Ensure that comprehensive management and coordination of enrollees' care includes coordination of care by network providers. Strengthening of procedures to ensure timely appointments, and the transfer of clinical information between the PCM and network provider, can improve appropriateness of care and increase satisfaction on the part of both enrollees and the network physicians.
- Evaluate the cost effects and readiness tradeoffs of bringing into the MTFs some of the Medicare-specific services that are being contracted to civilian providers, e.g., DME or home health.

DEMONSTRATION LESSONS FOR EFFECTIVE IMPLEMENTATION

The reports from the demonstration sites highlighted many of the sites' positive experiences and challenges during the start-up phase of TRICARE Senior Prime. We summarize here "key lessons learned" that the sites discussed with us during the site visits or that we identified in the course of analyzing information from the sites. The items are presented with the recognition that the relative usefulness of each item will depend on the unique circumstances of a specific Senior Prime plan. Additional detail is provided in the individual site reports in Appendix C. Some of these lessons can be applied quickly during the demonstration and, in some cases, the sites are doing just that. Others may be considered by HCFA Central and Regional Offices, TMA, and participating sites for any future expansions of Senior Prime.

Enrollment and Startup of Service Delivery

The following items address activities that Senior Prime plans may undertake as they plan for and carry out marketing and enrollment activities and begin service delivery for new enrollees. A good number of the lessons highlight the unique aspects of military health care and its interface with the Medicare program.

- Anticipate additional enrollment growth in existing sites under a permanent program, as some beneficiaries who were reluctant to enroll in a demonstration decide to join.
- To select an enrollment target for each Senior Prime plan, it is important to begin by assessing the plan's competitive advantages and liabilities in the market and estimating possible effects on financial performance of different enrollment levels. One of the issues that should be considered when setting these targets is the requirements of the readiness mission at each MTF.
- Careful design and execution of a marketing plan, guided by staff members or consultants with marketing expertise, will enhance the ability to achieve enrollment targets, while complying with HCFA marketing and enrollment requirements.
- The enrollment processing system should be streamlined, to reduce some of the delays and risks of error that MCS contractors have encountered as a result of having to verify eligibility in both the DoD and HCFA enrollment systems and to work with multiple information systems to activate beneficiaries' enrollment status. Ideally, effective dates of Senior Prime enrollment should mirror those of other Medicare health plans, which is the first day of the following month after a specified application cutoff date. (See discussion of data system issues below).

- Staging new enrollments over the initial months of Senior Prime operation is reported by the sites to be preferable to accepting all new enrollments immediately. With this approach, MTFs can process new enrollees effectively while working within its primary care clinic staffing capacities and maintaining TRICARE access standards. Payment methodologies and budgets need to allow for staging and account for its financial consequences.
- The' demonstration sites indicate there is value in careful and thorough orientation of beneficiaries to Senior Prime, followed by a program of education and health status screening for new enrollees and periodic educational activities on an ongoing basis. The benefits cited by the sites include early treatment and prevention of health problems, reduced confusion by beneficiaries, prevention of disruptions to care, and improved beneficiary satisfaction. Such an approach is resource intensive, however, and its long-term cost effectiveness is not yet documented. Both desired benefits and costs should be considered when designing a plan's intake methods.
- To ensure that the health care needs of new enrollees are being addressed appropriately, while avoiding excess costs for services that yield little value, the sites have found demand management techniques to be useful, that is, triaging of the needs of new enrollees and provision of appropriate levels of initial care. Health assessment forms or surveys geared to the elderly can serve as effective tools.
- Effective introduction of Senior Prime is aided by ensuring that primary care physicians and other front line clinical and administrative staff are well informed about Senior Prime and are active participants in (or lead) the educational programs for new enrollees. Ongoing provider education should be provided to ensure they remain well informed, given rotations of military staff and frequent turnover of civilian front line staff.
- Space-available beneficiaries may require assistance from MTF staff to help them make the transition to community providers because of reduced access to MTF care as Prime and Senior Prime enrollments increased.
- During transitions to Senior Prime enrollment, it is important to'identify early the enrollees who have existing treatment requirements (e.g., prescription medications, oxygen or other DME, home health care, ongoing therapies) and to make arrangements for continuing services without interruption. Strategies may include early queries of potential enrollees and working directly with the local service providers or suppliers to ensure that their records transfer patients to Senior Prime when enrollment is verified by HCFA.
- Considering the MTFs' experiences thus far in the demonstration, the largest, most specialized teaching medical centers appear to have encountered some of the more difficult transitions to establishing PCM clinics as Senior Prime gatekeepers who manage specialty referrals, apparently because medical centers' emphasis has been specialty care services and teaching. This issue appears to be more important in Senior Prime than TRICARE, perhaps because of the relatively more frequent referrals of older enrollees to specialists. With successful implementation of Senior Prime, the medical centers reportedly have gained benefits in improved patient care coordination and stronger support for GME.

Early Operation

The following items address the clinical care and administrative support activities that Senior Prime plans undertake as they provide services for enrollees. These items reflect our initial observations based on the very early operational experiences of the demonstration sites during the first 5 to 8 months of service delivery. We expect that other lessons will emerge as the demonstration proceeds and the sites mature as managed care plans.

- Given the complexity of Medicare+Choice rules, it would be useful for DoD and HCFA to review the compliance requirements to seek some systemwide approaches to reporting and monitoring that could reduce some overhead costs for HCFA regional offices and the LA Offices and MTFs.
- Physician productivity was improved in several of the site PCM clinics by re-configuring staffing patterns to include nurse manager functions, increases in support staffing depth, or reallocation of functions. Particular emphasis was placed on coordination of intake activities and follow-up visits for Senior Prime patients to manage health problems that were identified during intake, with reduced physician involvement.
- The demonstration has highlighted anecdotally how strongly Senior Prime enrollees value being able to talk to a person to make provider appointments and obtain customer service. Telephone appointment systems with automated menus tend to irritate or confuse older users. Of particular concern are the regionally centralized systems. Efforts to make these systems more accessible could increase enrollee satisfaction, while reducing time demands on front-line clinic staff to respond to complaints or questions. Some sites found it useful to provide training and support for enrollees to help them learn to use the systems.
- It is advisable to monitor activity for ancillary services to gain an understanding of the impact of Senior Prime on these services, identify tests or procedures being done externally that are high volume for an older population and can be brought inside the, MTF, and identify areas where inappropriate utilization may be occurring.
- Information about the Senior Prime program should be built into MTFs' ongoing orientation and continuing educational programs for providers, to ensure that the program becomes fully integrated into the MTFs routine operations.

Data System Capabilities

Even as DoD is making progress in strengthening its data systems, including the refinement and expansion of the CEIS as an management decision support system, the sites express their frustration at not being able to get complete, accurate, or timely data to support their current Senior Prime plan activities. The basic - and very demanding - need is to bring together DEERS, CHCS, ADS, HCSR, pharmacy claims, and other service use data, to calculate a variety of measures for utilization management and quality indicators for processes and outcomes of care. These indicators need to be measured consistently across all participating MTFs and the network provider services, to support establishment of national benchmarks of performance. In addition, timeliness of data is essential, to enable clinical teams to work with current data as they monitor and manage service utilization and provider performance.

The CEIS system is positioned to ultimately achieve the comprehensive information capability required for clinical decision making. Yet users still lack confidence in the completeness of the data that CEIS is capturing, and CEIS will not be fully useful for QM/UM monitoring and benchmarking until the systemwide data warehouse is broadly available to users.

Of course, the data in a system is only as good as the information being entered by users. The sites report highly varying levels of completeness of ADS data on outpatient encounters, ranging from less than 75 percent to more than 95 percent of outpatient visits having ADS sheets. Similar inconsistencies are reported for the quality of ADS sheet coding. Some sites report success in providing formal training for clinical staff on the importance of ADS and how to properly code diagnoses and procedures. Broader training initiatives are encouraged to improve the clinical integrity of the data in the systems.

The need for improvements in both the efficiency and accuracy of the processing of Senior Prime enrollments will become much more acute if Senior Prime becomes a permanent program with larger numbers of enrollees. An automation interface is needed that will allow MCS contractor staff to process enrollments with just one data entry and verification process that has automatic linkages among the DEERS, CHCS, and claims contractor systems (EAPP and CRIS), and the MCP. The introduction of such a capability can help standardize the Senior Prime enrollment processing methods across all participating MCS contractors.

NEXT STEPS FOR THE EVALUATION

As the first year of the subvention demonstration nears an end, RAND will be preparing to initiate several quantitative analyses of the impacts of the demonstration on beneficiaries and government costs, as summarized in Chapter 1 and described in detail in our Evaluation Plan (see footnote 8). The analysis of impacts on beneficiaries will focus first on examination of historical service utilization patterns for dual-eligible beneficiaries and any changes in those patterns after introduction of Senior Prime, with comparisons to control sites. The data used in this analysis also will be used in our cost impact analysis, which will begin to examine effects of Senior Prime on costs for both Medicare and DoD. Although it is too early to be able to detect most effects for quality of care, we plan to initiate this portion of our analysis as monitoring data become available from the sites.

Our analyses of enrollment demand and process evaluation work also will continue during the next year, including work in several specific areas.

Enrollment Demand:

- Continued documentation of enrollment trends for the demonstration sites, including patterns of age-in enrollments,
- Enrollment selection in Senior Prime enrollment as measured by risk scores based on the Medicare risk adjustment methodology,
- Analysis of frequency of disenrollments and possible contributing factors, and
- Multivariate analyses of factors influencing observed enrollment patterns.

Process Evaluation:

- Review of sites' records for Senior Prime grievances or appeals, to analyze frequency of events, distributions by cause, and features that may be unique to military health care;
- Documentation of any Senior Prime provisions or practices that the sites are transferring for application to TRICARE Prime;
- Estimation of Senior Prime start-up and operational administrative costs for the sites, including those incurred by the LA Offices, MTFs, and MCS contractors;
- Documentation of sites' activities in monitoring service utilization for Senior Prime enrollees, with specific focus on outpatient specialty visits and ancillary services;
- Analysis of beneficiary survey information to assess responses of dual eligibles to Senior Prime, reported satisfaction for those who enrolled, and reported effects on access to care. (detailed analysis of DoD beneficiary survey data and review of GAO survey reports);
- Continued analysis of market dynamics for Senior Prime plans, including interactions with other Medicare+Choice plans and with VA facilities serving the markets; and
- Monitoring of progress in implementing Medicare Partners in the demonstration sites.

Appendix A
List of Questions for Site Visits

QUESTIONS ABOUT SENIOR PRIME:

OVERALL STRATEGY FOR IMPLEMENTATION

What are the goals and overall strategies of this site for Senior Prime? Have they changed since the early phases of planning?

What types of decisions is the site making individually in designing its Senior Prime program?

What Senior Prime design decisions have the sites made collectively?

If the sites are making collective design decisions, for what types of decisions have they found this approach to be useful?

Which individuals at the site actually did the planning for Senior Prime? What were their respective roles?

In your view, what major decisions by DoD or HCFA have driven the implementation process?

Which decisions have been made by DoD or HCFA and which have been made locally by sites?

When designing the Senior Prime program, what views were sought or received from:

- retiree organizations or beneficiaries
- MTF physicians and other staff

How are the sites communicating and working with each other in addition to the regular meetings of the sites' representatives?

How have the experiences of the sites that implemented Senior Prime enrollment earliest been influencing the implementation strategies of other sites?

How is the site's early experience confirming or modifying implementation strategies?

What features do the sites see as unique to their catchment area and mission that need to be taken into account if Senior Prime were implemented systemwide?

INITIAL VIEWS OF THE SITES

What factors were initially thought to most strongly influence decisions by dual eligibles regarding Senior Prime enrollment and service utilization? What are your views now?

How was Senior Prime expected to affect patient satisfaction for dual eligibles and non-dual eligibles? What are your views now?

What benefits was Senior Prime expected to provide the MTF? What are your views now?

What concerns were there about the potential impact of Senior Prime on the ability of MTFs to serve non-dual eligibles, and the potential impact on access to care and patient satisfaction? What are your views now?

What effect was Senior Prime expected to have on the MTF's service delivery or overhead costs? What are your views now?

What were views initially about the effect of Senior Prime on the MTF's overall readiness mission? What are your views now?

COMPLIANCE WITH HCFA CONTRACTUAL REQUIREMENTS

How did the Lead Agent, MTF, and TRICARE contractor coordinate their respective roles in development of mechanisms to achieve compliance with HCFA requirements?

What actions were undertaken to meet the conditions for participation required for Medicare health plans?

What impacts did the actions taken for Medicare compliance have on other aspects of the sites' operations or health care delivery processes?

Which issues or challenges involved in qualifying as a Medicare health plan were shared by all the sites, and which were unique to individual sites?

What other issues arose during the Medicare health plan application process and how were they resolved?

MANAGEMENT STRUCTURE AND ROLES

What factors were considered in deciding the management structure for the Senior Prime program?

How are the Lead Agent, MTF, and TRICARE contractor coordinating their respective roles in Senior Prime management?

How have management roles changed since preparing the Senior Prime application? Why were changes made, if any?

How do the organizations work together to resolve problems that arise?

How has the MTF approached building a managed care team? How is Senior Prime integrated into other TRICARE managed care activity?

For early experiences, what aspects of Senior Prime management are:

- working especially well
- presenting challenges to resolve

STARTUP TRAINING AND PREPARATION

How are the Lead Agent, MTF, and TRICARE contractor coordinating their respective roles for training personnel for Senior Prime?

What new programs were established specifically to serve the Senior Prime enrollees? How are they working?

What training is being provided to MTF staff for delivering care to Senior Prime enrollees?

What clinical management challenges did providers find in preparing for service delivery?

What changes needed to be made to standard operating procedures for the Lead Agent, MTF, or contractor? How have the new procedures been working?

ENROLLMENT MARKETING AND PROCESS

How are the Lead Agent, MTF, and TRICARE contractor coordinating their respective roles in Senior Prime enrollment?

How was the decision made on the site's Senior Prime enrollment targets? What factors were considered?

Do you expect to meet those enrollment targets? What does this mean for meeting LOE and financial liability?

What is the overall strategy for marketing Senior Prime to dual-eligible beneficiaries?

How did the site's enrollment targets influence the approach taken to market Senior Prime to beneficiaries?

What pre-enrollment information is provided for the dual eligibles in addition to the materials prepared by DoD?

What procedures are established to keep the dual eligibles informed about Senior Prime and to address questions or concerns?

To what extent are efforts being made to educate non-dually eligible beneficiaries regarding effects of Senior Prime on their access to care? And to respond to concerns?

What new mechanisms did the TFUCARE contractor establish to manage Senior Prime enrollment activity?

Are TRICARE contractor staff and processes adequate to handle enrollment effectively?

Are enrollments being depressed because beneficiaries view the short 2-year life of the demonstration as too risky?

What unexpected delays or problems occurred in starting the enrollment process? How were they managed?

PROVIDER NETWORKS AND SERVICES

How are the Lead Agent, MTF, and TRICARE contractor coordinating their respective roles in developing mechanisms to achieve compliance with HCFA requirements?

To ensure the site could provide Medicarecovered services, what adjustments were made in:

- mix of MTF clinical staff
- MTF physical facilities
- MTF equipment
- TRICARE network providers

What options were evaluated for achieving the required provider mix?

What factors were considered regarding use of network providers?

For what services are network providers delivering care for the dual-eligible beneficiaries?

What modifications to existing provider contracts were needed to comply with Medicare requirements?

Does the site anticipate that changes in MTF clinical staffing may lead to inconsistencies with the provider mix required for the MTF's readiness and training mission?

How important was it to maintain staffing flexibility for Senior Prime due to potential deployments of clinical personnel?

If deployable personnel are an issue, how did the site consider the issue in staffing decisions?

What other impacts, if any, did provider changes have on the MTF's ability to provide services to non-dual eligible beneficiaries?

What unexpected delays or problems occurred in the start of service delivery to beneficiaries. How were they managed?

How are service coverage decisions made for Senior Prime enrollees as services are being provided? Who is involved in decisions?

What are early experiences in delivering services. Any highlights of areas of success or problems; implications for expansion of Senior Prime systemwide?

QUALITY ASSURANCE

How are the Lead Agent, MTF, and TRICARE contractor coordinating their respective roles in quality assurance planning and monitoring?

What approach has the site taken to respond to HCFA quality assurance requirements?

How was the quality assurance plan for the Senior Prime program developed? Who was involved?

How much was the MTF's existing QA plan modified to encompass Senior Prime?

How is the Senior Prime QA plan integrated with other QA activities, e.g., ORYX.

How have the QA plan goals or measures been modified since it was first developed?

What quality indicators have been identified as most important to monitor? Why?

What new quality indicators were added specifically for Senior Prime and why?

Are all the sites monitoring a set of common indicators? If so, how was the set chosen?

What data collection and reporting procedures are being used to monitor the quality indicators? How are service modification decisions made in response to QA findings?

What are the site's early experiences with beneficiaries in the grievance and appeal process? What issues are surfacing?

How is information on grievances and appeals being reported to site management? What actions have been taken by the site?

What are the site's early experiences with beneficiaries in the patient relations/customer affairs function? What complaints are being received?

How is information on complaints being reported to Senior Prime management? What actions have been taken by the site?

Is the site performing any customer surveys other than the DoD surveys? If so, what questions are asked, how frequently, and when are results reported?

IMPACTS ON GME/TRAINING

What value, if any, does Senior Prime offer for the hospital's training mission (if teaching)? What potential negative effects?

How is Senior Prime expected to affect specialty physician caseloads? What are the implications for medical education?

Do the various specialties have differing views regarding the value of Senior Prime for training?

MARKET POSITIONING FOR SENIOR PRIME

How would you characterize the Medicare managed care market dynamics in the service area?

How are local market dynamics influencing the site's implementation decisions?

Are many dual eligibles in the service area are enrolled in other Medicare health plans?

Do the other Medicare plans view the Senior Prime plan as serious competition?

What actions have you seen the other plans taking in response to entry of Senior Prime?

FINANCIAL CONSIDERATIONS

Is Senior Prime expected to be a financial benefit or liability for the site MTFs?

Does each MTF, and the site as a whole, expect to meet the LOE requirement?

What are the most important new costs being incurred for Senior Prime?

- Staff and other resource overhead costs
- Direct costs of delivering care

Which of the organizational and start-up activities, and related costs, that were committed to initiating Senior Prime will continue during ongoing plan operation?

If Senior Prime were extended broadly in the military health system how would start-up costs compare to those for the demonstration?

Is Senior Prime helping to achieve more efficient use of existing MTF physical plant that had not been fully used before?

EFFECTS ON SENIOR PRIME ORGANIZATIONS

How has Senior Prime changed operating circumstances most significantly for each of the following parties, and how have they responded?

- the Lead Agent's office
- the TRICARE contractor
- MTF management
- MTF physicians
- MTF clinical and support staff

How easy has it been for MTF staff to adjust to a managed care environment?

How has the workload of MTF staff changed with Senior Prime? How have they managed additional time demands, if any?

How has Senior Prime affected civilian provider organizations (e.g., home health)

EFFECTS ON BENEFICIARIES

How are dual eligible beneficiaries adjusting to a managed care environment?

What benefits or problems do beneficiaries expect to see from Senior Prime?

What are the key reasons why beneficiaries are enrolling in Senior Prime?

What specific concerns have the dual eligibles raised about Senior Prime? How has the site handled those concerns?

Are other DoD beneficiaries in the service area concerned about having less ready access to MTF services due to Senior Prime?

What other concerns have other DoD beneficiaries expressed? How are those concerns being handled?

QUESTIONS ABOUT MEDICARE PARTNERS:

INITIAL VIEWS OF THE SITES REGARDING MEDICARE PARTNERS

How likely is it that one or more Medicare health plans will approach the MTF for a Medicare Partners contract?

What benefits might the MTF gain by participating in Medicare Partners?

How might Medicare Partners affect the ability of the MTF to provide services for non-dual eligibles? How will that affect access to care and patient satisfaction?

What effect might Medicare Partners have on the MTF's direct and indirect costs?

How might Medicare Partners affect the MTF's overall readiness and training mission?

Appendix B
Template for Site Visit Agenda

DAY 1:

1. Individual courtesy meeting with the MTF/Lead Agent commander (15-30 min)
2. Introductory meeting with the command team and other key management staff (1 hr). RAND team provides an overview of the evaluation design and how the site visits fit into the evaluation. Then seek high level policy perspective from the command team regarding the subvention demonstration.
3. Tour of the medical treatment facility(s) (1 hr)
4. Group meeting with the Senior Prime management team (2 hrs) - focus on policy, organizational, and implementation topics from the management perspective
5. Meeting with the Senior Prime medical leadership (1 hr.) - medical directors of the MTF and Lead Agent office
6. QM/UM team meeting with counterparts from Lead Agent, MTF, and TRICARE contractor (Foundation Health) (1 hr.)
7. Focus group with representatives of retiree associations (1 hr.)

DAY 2:

8. Meeting with CEIS staff from Lead Agent's office (1 hr) -- discuss data availability, quality, and plans for reporting Senior Prime activity.
9. Meeting with the TRICARE Managed Care Support contractor managementteam (1-1/2 hr). (Often held at the contractor's office, but sometimes at the Lead Agent office.)
10. Focus groups with MTF health care delivery personnel (each 1-1/2 hr)--
    - PCM physicians
    - Specialty physicians
    - Front line clinical and support staff
    - Ancillary services staff

DAY 3:

10. Marketing team meeting - typically Lead Agent staff (1 hr)
11. Meeting with financial management staff - MTF and Lead Agent (1 hr)
12. Meetings with MTF and Lead Agent staff who deal directly with enrollees(each 1 hr)
    - Patient Relations
    - Senior Prime Appeals and Grievance
13. Outbriefing by RAND with the site's executive management team (1 hr) - RAND provides a preliminary overview of what was learned and highlights of items the site may wish to monitor or address.

Appendix C
Reports from the First Round of Site Visits

The Memorandum of Agreement (MOA) executed by the U.S. Department of Defense and Department of Health and Human Services provide for an independent evaluation of the demonstration, for which HCFA awarded RAND the contract in September 1998. One component of the evaluation is a process evaluation that is designed to:

- Document the activities and experiences of HCFA, DoD, the demonstration sites, beneficiaries, and other stakeholders as TRICARE Senior Prime and Medicare Partners are implemented;
- Generate qualitative information to help interpret the findings of quantitative analyses of the demonstration's effects on utilization patterns, access and quality, and costs; and
- Evaluate the implications of the documented experiences of stakeholders for broader implementation of Senior Prime or Medicare Partners across the military health system.

The process evaluation includes two rounds of visits to the subvention demonstration sites. The site visits are structured as shared learning activities, with the goal of learning from the sites' successes and challenges during the demonstration. In the first round of site visits in early 1999, we are collecting information on start-up and early operational experiences. In the second round of visits in late 2000, we will document structures and operations after the sites have had two years of experience with the subvention program. Between the two rounds of site visits, we will maintain quarterly contact with the sites to document changes in operation of the Senior Prime plans or Medicare Partner agreements and to identify issues that arise during the demonstration.

This Appendix contains site visit reports that highlight fmdings from the first round of site visits to subvention demonstration sites. In each report, we first provide a brief description of the site and its Senior Prime activities. We then discuss key points that we have identified with respect to the Senior Prime implementation and early operations, and we summarize lessons that the site stated they have learned thus far. Finally, we present implications and issues raised from our site visit findings. The reports are presented in the order in which the site visits were performed.

A central issue regarding data systems arose in all the site visits, which we identify here rather than in each site visit report because the sites share the issue. The multiple data systems involved in the collection and processing of data required to operate and monitor the Senior Prime plans has created a complexity that is vulnerable to errors and operational inefficiencies. These systems include the DoD DEERS enrollment system, CHCS clinical data and ADS ambulatory care data systems at the MTFs, the MEPRS data system on MTF workloads and finances, the MCS contractors' enrollment and claims processing systems, and the HCFA Medicare Processing Center that processes Medicare eligibility and Senior Prime enrollments. Successful implementation depends not only on valid data from each of these systems, but also on successful integration of activities across systems.

SUMMARY REPORT OF THE SAN DIEGO SITE VISIT
Site Visit Conducted on 20-22 January 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The three key participants in the San Diego Senior Prime plan are the Office of the Lead Agent for TRICARE Region 9, the San Diego Naval Medical Center, and Foundation Health Federal Services (FHFS), the Region 9 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, executed the Medicare+Choice plan contract with HCFA. The Medical Center is the sole military treatment facility (MTF) participating in the plan, and it serves as the primary provider of health care services to Senior Prime enrollees in this site. FHFS carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, and administrative services.[28]

Of the over 257,000 DoD beneficiaries in the San Diego market, about 14 percent are Medicare eligible and another 20 percent are retirees less than 65 years of age. The San Diego area is a highly penetrated managed care market, including 5 or 6 Medicare managed care plans that are serving 48 percent of the Medicare population. The Senior Prime plan is new competition for these existing Medicare plans.

The Naval Medical Center is a comprehensive tertiary facility with multiple clinical teaching programs. It has a combined mission of readiness, active duty support, and integrated health care delivery. The medical center has a bed capacity of approximately 300 beds, with an average daily census of 220 patients and more than 90,000 outpatient visits per month. Its pharmacy fills more than 3,800 drug prescriptions every day. The MTF can provide all standard outpatient and inpatient acute care services for Senior Prime enrollees, but it does not provide some Medicare-covered services that are required primarily by an older population. Civilian providers in the Senior Prime network provide these services.

PROGRAM DESIGN

Although the 6 demonstration sites share many common elements in their organizational structure, benefits covered, and service delivery system, the Naval Medical Center and the San Diego market have unique features that are reflected in the design of this TRICARE Senior Prime plan. FHFS brought in consultants with Medicare managed care expertise from elsewhere in the FHFS system, who advised the 3 sites it serves on designing Senior Prime and preparing for enrollment and operations.

Plan Leadership - With the establishment of the Office of the Lead Agent as the Senior Prime plan, the plan policy and management leadership were established at the TRICARE region level. This approach was done deliberately by the site in order to position the region for the possible expansion of Senior Prime in the future, through extension of the basic structure established for the demonstration.

Infrastructure - The San Diego Senior Prime plan was established within the Region 9 TRICARE framework as an adaptation of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted to its requirements. The Senior Prime Management Committee brings together the key organizational participants (Lead Agent, MTF, and FHFS) for coordination of policy and management. This Committee reports to the Executive Council of the TRICARE Regional Board of Directors. The site reports that such a unified corporate structure supports consistent decision making, reporting, and orderly response to issues, and it also helps integrate Senior Prime into the Region 9 TRICARE program.

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[28] The functions and responsibilities of the contractors for the TRICARE Senior Prime plans in all 6 demonstration sites are specified in Chapter 20 of the TRICARE Support Office Operations Manual.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the "richer of the Medicare or TRICARE Prime benefits," thus providing consistent health benefits at all Senior Prime sites. Yet this policy may constrain the ability of the San Diego plan to compete on benefits with other health plans, many of which are offering quite rich benefits to position themselves in a competitive Medicare managed care market.

Quality and Utilization Management System - The Senior Prime management team has adapted the region's well-established TFUCARE quality and utilization management programs for the Senior Prime plan. The QM/UM team is a collaborative effort among the staff responsible for QM and UM within each organization - the Lead Agent, MTF, and FHFS. There is a formal QM/UM committee within the TRICARE structure that oversees these activities for both TRICARE Prime and Senior Prime.

Provider Network - The four PCM clinics offer distinct options for Senior Prime enrollees, with an internal medicine clinic and a family practice clinic within the medical center and two clinics in other Naval facilities in the area. Many secondary and tertiary services also are provided in specialty clinics and inpatient units within the MTF. For services the MTF does not provide, the first sources of civilian care are the existing TRICARE Prime network providers. FHFS then contracts with new providers for services that are not available in the Prime network, including skilled nursing facility care, home health care, durable medical equipment, physical rehabilitation care, chiropractic care, burn care, and organ transplants.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - The San Diego site faced uncertainty periodically during the planning phase of the demonstration, as HCFA and DoD negotiated key decisions on program policy and design. One example of this issue was HCFA's introduction of the new Medicare+Choice rules to the Senior Prime plans. As the site was preparing for HCFA's site visit for its Medicare contract application, HCFA applied the Medicare+Choice rules to Senior Prime, thus changing the Medicare conditions for participation. In response to the new rules, the San Diego site revised its application, marketing, and enrollment materials immediately before the site visit. These "real time" events compressed the time available for the site to prepare for orientation of beneficiaries and program initiation. . . __

Start-Up Activities - Education and training were an important part of starting up Senior Prime in San Diego. The site trained the MTF staff first and then provided orientation for beneficiaries. Training meetings were held for all providers in July 1998, which were mandatory for physicians and open to all other staff. A reported 95% of clinicians attended the meetings. In addition the PCMs received l-on-l training. FHFS trained network providers at its central office for the 3 sites that FHFS serves. The site also undertook extensive outreach to provide information and orientation for dual eligible beneficiaries about the Senior Prime plan and their Medicare coverage options. More than 65 orientation meetings were held that were attended by almost 2,700 beneficiaries. Although their educational activities were broad-based, they were conducted in a compressed time period as a result of the time demands involved with switching to Medicare+Choice rules.

Enrollment - The rates of Senior Prime enrollment in San Diego have been slower than expected. Only 2,100 of the targeted 4,000 enrollees had enrolled by the end of January 1999, but new enrollees continue to join at a rate of about 100 per month. Many are Medicare-eligible beneficiaries who are taking time to decide whether to join Senior Prime, and plan managers expect that these enrollments will continue for a while. The remainder are TRICARE Prime enrollees who are aging in to Senior Prime at a steady pace of 50 or more each month. The site reported that retiree associations in the area had advised their members to be cautious about enrolling in a two-year demonstration and not to give up their Medicare supplemental courage. These activities may have contributed to the slower rates of enrollment. In addition, PCM physicians and front-line clinical and support staff reported that many beneficiaries were

confused initially regarding the enrollment process, and non-enrollees were concerned about whether they would lose access to space-available care.

There is strong consensus that the slower enrollment was good for the Senior Prime plan and the Medical Center. More flexibility was available to gear up service delivery and manage enrollees' initial PCM visits without severely compromising access to care for other beneficiaries. Full enrollment immediately would have stressed the clinics' capacity to their limits or beyond.

Service Delivery - All new Senior Prime enrollees were scheduled for first visits at the PCM clinics, at which they were screened for health status. This process identified many people with unmanaged health problems who needed follow-up care. In contrast to earlier expectations that clinic activity would decrease after the initial visits, follow-up services for enrollees with health problems now are expected to place continuing demands on the clinics, thus reducing capacity for space-available care. Transitions to Senior Prime providers were reported to be made smoothly for many enrollees who had existing services for chronic conditions. FHFS added new network providers or specialty services as demand documented the need. For some enrollees who were using non-network providers, and had to switch to network providers, the temporary unavailability of some services (e.g., DME) was reported to interrupt access during the transition.

Quality and Utilization Management Processes - As the Senior Prime staff are preparing to meet HCFA's QISMC quality requirements, they have adopted a data-driven approach to define priorities based on documented need for improvements in clinical processes or efficiency. The site is working with the Senior Prime compliance committee at the DoD level to establish consistent indicators across the sites. Data limitations, especially ADS data, are hampering their ability to measure indicators readily.

Financial Performance - The financial impact on the MTF from the administrative demands of implementing Senior Prime were small, relative to the facility's overall budget. They report that no funds were allocated for start-up because all the work at the MTF was done by existing staff. Senior Prime is being introduced at a time of declining third party reimbursements to the MTF, where reimbursements have decreased $1.5 million from previous years. They plan to estimate the financial impact of Senior Prime on service delivery costs at mid-year. Specialty clinics are not liable for new specialty care costs generated by older patients, but the costs are reported on their financial statements so they can see what they are. With recognition that LOE reconciliation credits and cash flow decisions are handled at the service level within DoD, little concern was expressed about whether the medical center would see any cash for the Senior Prime services it provided.

Dynamics of the Local Medicare Managed Care Market - The Senior Prime plan is a new entry to an extremely competitive managed care market, including health plans with high rates of Medicare enrollments. Many of the Senior Prime enrollees previously had been members of other Medicare plans. These enrollees are already accustomed to a managed care environment and are savvy consumers of medical care. Because these plans have such large enrollments, however, the impact on them likely is small even if they lose hundreds of enrollees to Senior Prime.

Early Lessons Learned by the Site

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees' service needs.
   - A large number of enrollees signed up immediately for the Internal Medicine Clinic, resulting in almost immediate filling of the clinic's service capacity.
   - Approximately 80% of the enrollees were new patients for the PCM clinics, but not necessarily new to the MTF because many were patients of specialty physicians.
   - Enrollee satisfaction is high due to improved access to care and TRICARE benefits.
   - Through flexibility and expansion of clinic capacity, the MTF has met TRICARE access standards for both Prime and Senior Prime enrollees.

- Croup orientations for new enrollees are a functional tool in educating them regarding providers, processes, and contact information; and may be a key in the future.
- Providers had a critical role in marketing Senior Prime and increasing enrollments.
- Providers and Health Benefits Advisors have important roles in working with space-available beneficiaries whose access to MTF care has decreased and with eligible beneficiaries who have not, yet enrolled.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - The transitional impact on space-available beneficiaries is not yet known.
   - During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) and be flexible in managing their care.
   - Care to Senior Prime enrollees provided outside of the hospital needs to be monitored carefully.
   - Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
   - Strong communication among the MTF, Lead Agent, and FHFS is essential to managing compliance issues that require resolution and documentation.
   - Use of Resource Sharing assets should be permitted for Senior Prime.
   - Extensive coordination between the MTF and network case management teams is required for continuity of patient care.
3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management.
   - No mental health benchmarks are available for use in monitoring.
   - System-generated reports should be available for utilization management for civilian providers (data currently is collected manually).
   - Benchmark quality and access data for the dual eligible population is needed in CEIS.
   - Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
   - Additional physician training is needed on HCFA rules for documentation and coding.

IMPACTS ON BENEFICIARIES

Although this site visit did not include focus groups with beneficiaries or leaders of retiree associations, focus groups were conducted with front line PCM physicians and other clinical and support staff. These sessions generated information about the feedback that MTF staff have been hearing from beneficiaries who received care at the medical center, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
- Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
- Some feel forced into Senior Prime as the only way to gain access to the Medical Center, as they observe shrinkage of space-available care.
- Senior Prime enrollees appear to have gained better access to care and continuity of services.
- Substantial confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee.

- Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions are losing specialists who were providing both their specialty and primary care.
- Beneficiaries need continuing support and education as they make changes in enrollments and service providers; some of the initial confusion will abate, but much probably will continue.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Naval Medical Center

- Because the Medical Center already had served many older patients, introduction of Senior Prime has had only modest effects on MTF administrative and operating costs or shifts in patient mix toward an older population.
- PCM clinics' service patterns have changed from provision of episodic care to active care management for their enrollees.
- Emphasis on case management has grown and may extend into care for Prime enrollees.
- Communication between primary care clinicians and specialists has improved as patients are referred and treated, and it is being accelerated by case management activities.
- The specialty care needs of older populations are supporting the medical education mission.
- Impacts of Senior Prime on the MTF's readiness mission are reported to be small because the MTF has an established backfill plan, tends not to have large deployments, and the beneficiaries understand the importance of readiness and are willing to adjust health care use when deployments occur.
- Efforts are increasing to improve data resources to support QMAJM activities.
- Some confusion and negative views of Senior Prime have been expressed by physicians, clinical, and support staff due to introduction of new service delivery methods under managed care and an incomplete understanding of the Senior Prime program.

Lead Agent

- Leadership responsibility has increased, accompanied by redefinition of the Lead Agent functions and an increase in resource requirements.
- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- Lead Agent staff resources have been increased in response to these expanded roles.

Foundation Health Federal Services

- Workload has increased as FHFS has supported the new enrollee population.
- The FHFS enrollment system has been expanded and modified for Senior Prime enrollments.
- New demands are placed on FHFS staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- Contracting activities have increased as FHFS has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.
- FHFS has added staff in both its home office and Region 9 office to accommodate these new responsibilities and caseloads. Because FHFS is the TRICARE contractor for 3 subvention sites, they have achieved some efficiencies in their new Senior Prime functions.

Other Organizations

- The VA may lose some beneficiaries to Senior Prime, but at the same time gain some who do not join and are crowded out as space-available care decreases.
- Other Medicare health plans in the market are experiencing observable loss of enrollment, but the losses appear to have limited effects on the very large plans.

IMPLICATIONS AND ISSUES

The early experiences of the San Diego site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

- Timely addition of new specialty providers specific to Medicare populations,
- Training of specialty physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
- Responsive actions to identify and correct operational problems during enrollments,
- Ensuring access to case managers for all PCM clinics,
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
- Preparation for timely handling of grievances and appeals,
- Access to the data needed to monitor program activities and manage quality and utilization.

Many of these factors become critical in the context of system-wide implementation of Senior Prime, where a regional Lead Agent office will be managing start-up and operational processes across multiple MTFs. To establish the program across a region successfully, the Lead Agent will need to have a combination of the necessary authority and adequate resources.

SUMMARY REPORT OF THE MADIGAN/REGION 11 SITE VISIT
Site Visit Conducted on 23 – 25 February 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The three key participants in this Senior Prime plan are the Office of the Lead Agent for TRICARE Region 11, Madigan Army Medical Center (MAMC), and Foundation Health Federal Services (FHFS), the Region 11 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, executed the Medicare+Choice plan contract with HCFA. The Medical Center is the sole military treatment facility (MTF) participating in the plan, and it serves as the primary provider of health care services to Senior Prime enrollees in this site. FHFS carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, and administrative services.

Of the over 138,000 DoD beneficiaries in the Seattle-Tacoma market, about 14 percent are Medicare eligible and another 37 percent are retirees less than 65 years of age. The Seattle-Tacoma area is a highly penetrated managed care market, including 6 Medicare managed care plans that are serving 28 percent of the Medicare population. The Senior Prime plan is new competition for these existing Medicare plans. Madigan Army Medical Center is the demonstration site with the most experience in managed care. Reorganization of their organizational structure and service delivery systems occurred in 1995 with the start-up of healthcare delivery under the first TRICARE contract. Prior to that, in 1992 MAMC had begun implementing managed care under the Army's Gateway to Care. Thus, the beneficiaries served by MAMC are accustomed to managed care concepts, so transition to Senior Prime as a Medicare health plan was accomplished fairly easily.

Madigan Army Medical Center is a comprehensive tertiary facility with multiple clinical teaching programs. It has a combined mission of readiness, GME, active duty support, and integrated health care delivery. The medical center has a bed capacity of approximately 172 beds, with average daily admissions of 45 patients and more than 950,000 outpatient visits per year. The MTF can provide almost all of the standard outpatient and inpatient acute care services for Senior Prime enrollees, but it does not provide some Medicare-covered services that are required primarily by an older population. Civilian providers in the Senior Prime network provide these services.

PROGRAM DESIGN

Although the 6 demonstration sites share many common elements in their organizational structure, benefits covered, and service delivery system, Madigan Army Medical Center and the Seattle-Tacoma market have unique features that are reflected in the design of this TRICARE Senior Prime plan. FHFS brought in consultants with Medicare managed care expertise from elsewhere in the FHFS system, who advised the 3 sites it serves on designing Senior Prime and preparing for enrollment and operations.

Plan Leadership - With the establishment of the Office of the Lead Agent as the Senior Prime plan, the plan policy and management leadership was established at the TRICARE region level. This approach was done deliberately by the site to position the region for the possible expansion of Senior Prime in the future, building upon the basic structure established for the demonstration.

Infrastructure – The Senior Prime plan was established within the Region 11 TRICARE framework as an extension of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted to its requirements (one example being the quality management function). The ground work for the success of this site in starting up Senior Prime was laid by having an existing TRICARE management structure and working relationships, as well as familiarity with a managed care environment. The TRICARE Senior Prime Management Committee brings together the key organizational participants (Lead Agent, MTF, and FHFS) for coordination of policy and management. This Committee reports to

the Executive Council of the TRICARE Regional Board of Directors, helping to integrate Senior Prime into the Region 11 TRICARE program.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the "richer of the Medicare or TRICARE Prime benefits," thus providing consistent health benefits at all Senior Prime sites. This policy may constrain the ability of the Madigan/Region 11 plan to compete on benefits with other health plans in a highly competitive market, although the supplemental benefits offered by other plans may also be constrained by the relatively low Medicare capitation rates in this market. There is a strong consensus at the site that TMA needs to clarify the details of what specific services and limits are covered by the Senior Prime benefits.

Quality and Utilization Management System - The Senior Prime management team has adapted the region's well-established TRICARE quality and utilization management programs for the Senior Prime plan. The QM/UM team is a collaborative effort among the staff responsible for QM and UM within each organization - the Lead Agent, MTF, and FHFS. There is a formal QM/UM committee within the TRICARE structure that oversees these activities for both TRICARE Prime and Senior Prime.

Provider Network - Two PCM clinics within the medical center - an internal medicine clinic and a family practice clinic - offer distinct options for Senior Prime enrollees. Many secondary and tertiary services also are provided in specialty clinics and inpatient units within the MTF. For services the MTF does not provide, the first sources of civilian care are the existing TRICARE Prime network providers. FHFS then contracts with new providers for services that are not available in the Prime network, including skilled nursing facility care, home health care, durable medical equipment, physical rehabilitation care, and chiropractic care.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - The Region 11 site was the first to be processed for Medicare certification, and the Medicare standards and processes changed during this time as HCFA established the Medicare+Choice rules and HCFA and DoD continued negotiations on program policy and design. When HCFA applied the new Medicare+Choice rules to the Senior Prime plans, this site revised its Medicare certification application and modified procedures to comply with the new rules.

Start-Up Activities - Education and training were an important part of start-up for Senior Prime in Region 11. This site started early with electronic education sent to the MTF staff. The Lead Agent and Commander of Madigan Army Medical Center briefed the MTF's Department Chiefs, who in turn were responsible for briefing their personnel. Ongoing staff education continues on features of the Senior Prime Program and the Medicare+Choice program, using "TSP nuggets" on CHCS and a staff newsletter with tips on how to better serve the Senior Prime population. FHFS trained network providers at its central office for the 3 sites that FHFS serves.

The site also undertook extensive outreach to provide information and orientation for dual eligible beneficiaries about the Senior Prime plan and their Medicare coverage options. The approach used was to educate as many as possible across the service area about Senior Prime. FHFS hired temporary staff to assist with the beneficiary orientations. The educational activities were broad-based, but they were conducted in a compressed time period as a result of the time demands involved with implementation of the Senior Prime program. Marketing overall appeared to have been a success on several different levels:

- controlled personalized marketing to the beneficiaries
- maximum use of community resources (e.g., retiree associations, informing congressional liaison)
- multi-pronged approach to marketing and education
- employment of a train-the-trainer methodology to educate the providers

This site had the strong support of local retiree associations that enabled marketing efforts to focus on beneficiaries' needs and requirements. As comprehensive as the marketing process was, there were small

pockets of individuals (e.g., those who speak English as a second language, widows, those not affiliated with a retiree association) who were not reached, which might be expected in the start-up of any such program.

Enrollment - The rate of Senior Prime enrollment in the Region 11 Senior Prime Program was high. This MTF was serving approximately 3,800 impaneled elderly patients. Although they had expected many of these beneficiaries to enroll in Senior Prime, only 50 percent of them actually enrolled and the remaining enrollees previously were episodic users of the MTF. A number of Medicare-eligible beneficiaries decided not to enroll due to concerns regarding the temporary nature of the demonstration. Others could not enroll because they were not eligible for Senior Prime (e.g. did not have Part B or were located outside of the designated zip code areas). Primary care managers (PCMs) reported there was some initial confusion about how the beneficiaries were going to be accepted into Senior Prime, either by a lottery or on a first-come/first-served. There also were instances where families were split up, with a spouse being accepted into Senior Prime, but not the veteran. Some beneficiaries had not received enrollment information early enough to sign-up for the program. Confusion on the part of some beneficiaries continues, e.g. as to whether they are enrolled in the program or what their PCM clinic is. A key lesson from the Madigan enrollment experience was the logistical difficulties involved in opening enrollment for a large number of beneficiaries as a "bulk" enrollment. The Medical Center had 3,300 Senior Prime beneficiaries enroll at once, which severely tested its clinics' capacities. Given the decision to use bulk enrollment, the Region 11 site provided exceptional responses to get the Senior Prime enrollees integrated into its managed care system. In addition, TRICARE Prime beneficiaries are aging in to TRICARE Senior Prime at a steady pace of about 25-30 or more each month. At the time of the RAND site visit, approximately 600 Senior Prime enrollees had not been able to attend the orientation sessions with some being either in a SNF or in custodial care. Currently, there is no mechanism for readily identifying those who might be in group homes or in assisted living arrangements.

Service Delivery - All new Senior Prime enrollees were scheduled for first visits at the PCM clinics, at which they were screened for health status and existing health conditions. This process identified many enrollees who had not been seen for some time by any provider, had unmanaged health problems requiring follow-up care, or required medication refills. PCM providers found that some new patients did not have their medical records from their civilian providers. During the orientation process, flu and health screens were conducted and Put Prevention into Practice (PPIP) flow sheets were given out to the beneficiaries. Follow-up was not possible, however, due to limited resources. A new program for the elderly was initiated by the MTF entitled the Sensational Senior group open to all over 65 year olds. The program emphasizes health programs to meet the needs and desires of the SENIOR PRIME population followed by a social hour and the opportunity to participate in focus group discussions aimed at addressing questions or concerns regarding the Senior Prime Program or services in general.

Transitions to Senior Prime providers were reported to be smooth for many enrollees who had existing services for chronic conditions. Every eligible beneficiary was given a questionnaire developed by the Social Work Department to identify those who had special needs; lived alone or had poor support systems; or had other special needs such as personal care, household chores, and transportation. FHFS added new network providers or specialty services as demand documented the need for doing so. For some enrollees who were using non-network providers, and had to switch to network providers, the temporary unavailability of some services (e.g., DME) was reported to interrupt access during the transition.

The pharmacy benefit currently is open to all beneficiaries no matter where their care is received. The MTF's pharmacy data show increased usage of the pharmacy by Senior Prime enrollees. The pharmacy staff postulate that some patients receiving care from civilian providers might have prescriptions that are not on the formulary, which normally are not filled by the MTF pharmacy. However, as Senior Prime enrollees, patients now can get a non-formulary medication should their provider deem it necessary.

The medical staff had the perception that a number of enrollees had high acuity health problems. Therefore, rather than declines in clinic activity after the initial visits, follow-up services for enrollees with health problems are expected to place continuing demands on the clinics, thus reducing capacity for space-available care over the long-term. Specialty providers highlighted the differing capacity across specialty and subspecialty clinics to absorb referrals of Senior Prime enrollees. The unevenness of availability across given specialties and subspecialties has been a problem for a while, and it has become even more pronounced since Senior Prime started. Some specialty care clinics are essentially closed to Medicare patients, whereas other specialty clinics may have unused capacity.

Madigan Army Medical Center continued to provide care to Medicare-eligible beneficiaries who did not enroll in Senior Prime for three months after the start-up, to give them adequate time to find other primary care providers. These individuals also were provided assistance by MTF staff to help them understand their other options. The Medical Center would still like to be the preferred specialty care provider for these elderly beneficiaries to help support its GME programs. There are not sufficient Senior Prime enrollees to sustain subspecialty training programs such as general surgery, or urology, so it is important to be able to continue to serve space-available elderly patients. However, without Medicare Partners there is no mechanism for reimbursement for these services.

Quality and Utilization Management Processes - Before implementation of Senior Prime, this site already had a strong quality and utilization management process for TRICARE, which was extended to include the Senior Prime program, including conduct of quarterly performance meetings to meet specific HCFA requirements. Under the TRICARE model, Madigan organized into various multidisciplinary managed care teams that serve individuals' health care needs on a continuum. Separating the age 65+ population from the TRICARE Prime population has been a challenge. The site is working with the DOD-level Senior Prime quality management committee to establish consistent indicators across the sites. Data limitations, especially problems with the ADS data, are hampering their ability to measure such indicators readily. The site also plans to collect QM/UM data for the non-enrolled population.

Financial Performance - A strong concern expressed by Region 11 site participants was the financial impacts of the administrative costs required to implement Senior Prime. No funds were allocated for start-up, and existing staff at the MTF and Lead Agent office performed all the work. In addition, Senior Prime is being introduced at a time of declining third party reimbursements to the MTF. This site plans to estimate the financial impact of Senior Prime on service delivery costs at mid-year. Concern was expressed about whether the medical center would see any funds for the Senior Prime Services it provided. Further, the data systems are not in place to provide timely financial performance information. Concern also was expressed that Senior Prime may be a financial liability at this site, given the low Medicare capitation rates (averaging $265 per member per month), to which TMA has applied a $90 withhold for SNF and home health care. This site also is concerned that enrollee demographics may work against the MTF in risk adjustment of payments, which they cannot verify yet because the adjustment will not occur until the year-end reconciliation. Other concerns included the increasing LOE thresholds over time, understanding the LOE methodology, and the higher acuity of enrollees that may result in high costs for SNF and home health care. The AMEDD financial office has not been able to provide good financial reports yet, so the MTF cannot verify and validate their financial performance and impacts.

Dynamics of the Local Medicare Managed Care Market - The Senior Prime plan is a new entry into a highly competitive managed care market, including health plans with high rates of Medicare enrollments. Some of the Senior Prime enrollees previously had been members of other Medicare plans. Thus, many enrollees were already accustomed to a managed care environment. The impacts on these health plans as enrollees switch to Senior Prime will depend on how many enrollees the plans lose relative to the sizes of their total Medicare enrollments. It is worth noting that the bulk enrollment done by this site did result in a one-time loss of several hundred enrollees by the largest health plan in the area.

EARLY LESSONS LEARNED BY THE SITE

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees' service needs.
   - Enrollee satisfaction is high due to improved access to care and TRICARE benefits.
   - Non-enrollees are concerned about their ability to continue to access the facility on a space-available basis and will require education as well.
   - Through flexibility and expansion of clinic capacity, the MTF is meeting TRICARE access standards for both Prime and Senior Prime enrollees.
   - Controlled personalized marketing and group orientations for new enrollees are important tools in educating beneficiaries regarding providers, processes, and contact information.
   - Bulk enrollment is not an effective intake strategy if the site has large enrollments that could overload clinic capacities. Phased-in enrollments enable a facility to better accommodate new enrollees within available capacity.
   - Providers and Health Benefits Advisors have important roles in working with space-available beneficiaries whose access to MTF care has decreased and with eligible beneficiaries who have not yet enrolled. Assistance should be provided to those beneficiaries who will need to make the transition to a community providers.
   - The train-the-trainer methodology utilized by this site was successful due to the top priority given to Senior Prime at the command-level and the multiple strategies employed for educating providers.
   - Certain "pockets" of retirees who are difficult to reach through normal marketing mechanisms may require particular attention during outreach efforts if Senior Prime was implemented more widely.
   - The enrollment application should include questions to identify Senior Prime enrollees who may be living in group homes or assisted living arrangements.
   - If Senior Prime is rolled out nationwide, it will be important to educate both the Medicare beneficiaries and other DoD beneficiaries who may no longer be using the site's MTF.
2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - The impact of Senior Prime on space-available beneficiaries is not yet known.
   - During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) and be flexible in managing their care.
   - Care to Senior Prime enrollees provided outside of the hospital needs to be monitored carefully.
   - Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
   - Strong communication partnering relationship among the MTF, Lead Agent, and FHFS is essential to managing compliance issues that require resolution and documentation.
   - Use of resource sharing personnel should be permitted for Senior Prime. A mechanism for reimbursement must be developed.
   - Extensive coordination between the MTF and network case management teams is required for continuity of patient care.
   - A number of Senior Prime patients have multiple medication needs that make them high risk for adverse drug interactions; particularly if they receive the medications from multiple sources. The pharmacy options for these patients should be limited to the MTF so that they may be properly managed. The addition of a geriatric pharmacist to the MTF staff would also be beneficial.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems is barriers to effective QM/UM management.
   - Benchmark quality and access data for the dual eligible population is needed in CEIS.
   - Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
   - Additional physician training is needed on HCFA rules for documentation and coding.

IMPACTS ON BENEFICIARIES

We summarize here what we learned during our focus groups with the leaders of retiree associations, PCM physicians, specialty providers, and other front line clinical and support staff. These sessions generated information from the feedback that MTF staffs have been hearing from beneficiaries who received care at the medical center, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
- Senior Prime enrollees appear to have gained better access to care and continuity of services.
- Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
- Some feel "forced" into Senior Prime as the only way to gain access to the Medical Center, as they observe shrinkage of space-available care, which they may perceive as a "breaking of trust" with them, especially for those who previously had been impaneled.
- Senior Prime enrollees are reporting to their retiree association representatives that they are very satisfied with the care they were receiving, and they feel that the health care program at Madigan Army Medical Center is outstanding.
- There are some concerns about the limited enrollment for the demonstration and many would like to see Senior Prime opened up to all elderly retirees in the area as soon as possible.
- Some confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee.
- Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions have lost the specialists who were providing both their specialty and primary care.
- Beneficiaries need continuing support and education as they make changes in enrollments and service providers; some of the initial confusion will abate, but much probably will continue.
- There is concern about what will happen to Senior Prime enrollees when the demonstration ends, and what will be the impacts on those who dropped their Medicare supplemental insurance.
- Retiree organization leaders noted concerns about the long-term impact of Senior Prime and the availability of funding to continue the program, and even increase its size in the future.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Madigan Army Medical Center

- Introduction of Senior Prime has had substantial effects in certain areas of the MTF. Administrative and operating costs for the MTF have increased with a shift in patient mix toward an older population.
- PCM clinics' service patterns have changed from provision of episodic care to active care management for their enrollees.
- Communication between primary care clinicians and specialists has improved as patients are referred and treated.

- The specialty care needs of older populations are positive for the MTF's training/GME mission. However, some GME programs are at risk of losing the patient mix and volume needed to support their program due to shrinking capacity for space-available care.
- Impacts of Senior Prime on the MTF's readiness mission are reported to be of some concern.
- Efforts are increasing to improve data resources to support QM/UM activities.
- If this program is to be expanded to all MTFs, each MTF would require a dedicated staff for Senior Prime, given the administrative burden.

Lead Agent

- Leadership responsibility has increased, accompanied by redefinition of the Lead Agent functions and an increase in resource requirements.
- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- If this program is expanded to all MTF's in the region then the Lead Agent office would request additional mobile staff.

FOUNDATION HEALTH FEDERAL SERVICES

- New workload demands are placed on FHFS staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- The FHFS enrollment system has been expanded and modified for Senior Prime enrollments.
- Contracting activities have increased as FHFS has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.
- FHFS has added staff in both its home office and Region 11 office to accommodate these new responsibilities and caseloads. Because FHFS is the TRICARE contractor for 3 subvention sites, they have achieved some efficiencies in their new Senior Prime functions.

Other Organizations

- Other Medicare health plans in the market are experiencing observable loss of enrollment, but it is not yet known what effects this may be having on the other health plans. . .

IMPLICATIONS AND ISSUES

The early experiences of the Region 11 site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

- Controlled personalized marketing to build confidence on the part of enrollees,
- Timely addition of new specialty providers specific to Medicare populations (e.g. Geriatric Clinic, Geriatric pharmacist),
- Training of specialty physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
- Responsive actions to identify and correct operational problems during enrollments,
- Ensuring access to case managers for all PCM clinics,
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them
- Preparation for timely handling of grievances and appeals,
- Access to the data needed to monitor program activities and manage quality and utilization.

The initiative by the Region 11 site was an important component of the overall success of its Senior Prime start-up. For example, the Senior Prime management committee at the Region 11 site was able to influence the implementation timeline. The management committee also understood the complexity of

the startup process and were proactive in making sure that key design and administrative issues were being addressed. The Region 11 administrative leadership was persistent in ensuring open communication early on with the HCFA Regional Office, and they helped to bring together the other sites to work on common issues and processes.

SUMMARY REPORT OF THE REGION 6 (SAN ANTONIO/TEXOMA) SITE VISIT
Site Visit Conducted on 22-25 March 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The Region 6 site is the largest and most complex of the six subvention demonstration sites. The organizations participating in the Region 6 Senior Prime plan are the Office of the Lead Agent for TRICARE Region 6, four military treatment facilities (MTFs), and Foundation Health Federal Services (FHFS), the Region 6 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, is accountable to HCFA for the site's performance as a Medicare+Choice plan. The four participating MTFs are Brooke Army Medical Center and Wilford Hall Medical Center in San Antonio and Reynolds Army Community Hospital and Sheppard Air Force Base Hospital by the Texas-Oklahoma border (Texoma). These MTFs serve as the principal providers of health care services to the site's Senior Prime enrollees. FHFS carries out various functions on behalf of the Lead Agent, including the enrollment process, network management, portions of utilization management (UM)/case management (CM), and administrative services.

The site encompasses two geographically distinct service areas. San Antonio is an active managed care market, including 4 Medicare health plans that are serving 34 percent of the Medicare population. The Senior Prime plan is new competition for these existing Medicare plans. By contrast, there is little managed care in the Texoma market, with only 2 Medicare managed care plans serving 4 percent of the Medicare population. Over 999,100 DoD beneficiaries reside in Region 6, and about 17 percent (162,300) of these beneficiaries are Medicare eligible and another 42 percent are retirees or dependents less than 65 years of age. About 20 percent of the Medicare-eligible DoD beneficiaries in Region 6 live in the San Antonio Senior Prime service area and 4 percent live in the Texoma service area.

TRICARE was implemented in Region 6 in 1995, so the Lead Agent office and MTFs have experience with managed care, and the DoD beneficiaries in most parts of this region are accustomed to managed care concepts. Beneficiaries in San Antonio made a fairly easy transition to Senior Prime as a Medicare health plan, but the site faced a few challenges in establishing Senior Prime service delivery in the Texoma service area because of some resistance to managed care in that market.

The MTFs serving the San Antonio and Texoma service areas differ substantially in their characteristics and service mix. As shown in Table 1, Brooke AMC and Wilford Hall MC are large; comprehensive tertiary facilities that operate multiple clinical teaching programs. These MTFs have the capability to provide all but a few sub-specialty services for their Senior Prime enrollees. Reynolds ACH and Sheppard AFB Hospital are smaller community hospitals that provide a balanced mix of primary care and specialty services and they do not have medical education programs. There is more use of Senior Prime network providers in Texoma than in San Antonio because the Texoma MTFs provide fewer specialty services.

PROGRAM DESIGN

The Region 6 TRICARE Senior Prime plan provides a useful test case of how regional Senior Prime plans might operate if subvention was implemented more broadly across the DoD health system. Although TMA established this site as a four-MTF plan, TMA left decisions regarding the site's organization and procedures to the site itself. In the model developed by the site leadership, the Lead Agent office plays a strong role in managing and coordinating enrollment and service delivery among the 4 MTFs and FHFS as the support contractor. FHFS brought in consultants with private-industry Medicare managed care expertise from within the FHFS system who advised the Region 6 site and two other demonstration sites served by FHFS on designing Senior Prime and preparing for enrollment and operations.

Table 1
Profiles of the Military Treatment Facilities in the Region 6 Senior Prime Plan

	San Antonio Service Area		Texoma Service Area	
	Brooke Army Medical Center	Wilford Hall Medical Center	Reynolds ACH, Ft. Sill	Sheppard APB Hospital
Military Service	Army	Air Force	Army	Air Force
MTF service profile:				
Bed capacity	238	350	150	60
Dispositions (discharges)	10,410	21,992	3,792	3,302
Outpatient visits	610,516	972,955	458,122	199,594
Ambulatory surgeries	9,523	3,689	1,122	600
Provided by MTF:				
Specialty care	Most	Most	Some	Some
Tertiary care	Yes	Yes	No	No
Medical education (GME)	Yes	Yes	No	No

Plan Leadership - With the Office of the Lead Agent serving as the Senior Prime plan, policy and management leadership were established at the TRICARE region level, and 5 full time staff operate the project with additional part-time support from several other staff. The Lead Agent office prepared a written Memorandum of Understanding with each MTF that specified the roles and responsibilities of the Lead Agent and the MTF for enrolling and serving Senior Prime beneficiaries at that MTF. The site used this approach to position the region to build upon its basic organizational structure at such time Senior Prime is expanded in the future.

Infrastructure – The Senior Prime plan was established within the Region 6 TRICARE framework as an extension of TRICARE Prime, and already existing TRICARE systems and processes were adapted to its requirements. The commanders of the 4 MTFs and Intermediate Service Command representatives serve on the Senior Health Plan Board of Directors, reflecting the military chain of command where resources flow through the MTF command structure to the MTFs, rather than through TRICARE. Representatives of the Lead Agent office and FHFS serve as non-voting members of the board. This board reports to the national TRICARE Board of Directors. The TRICARE Senior Prime Management Committee is led by Lead Agent office staff and brings together the key organizational participants (Lead Agent, MTF, and FHFS) for coordination of policy and management. This committee reports to the Senior Health Plan Board of Directors.

A Quality Council reports to the Senior Health Plan Board. Under the originally planned structure, two Consumer Advocacy Committees would have reported to the Quality Council. However, based on recent feedback from MTF personnel and beneficiaries, the Board determined it would be more appropriate to incorporate Senior Prime representation into existing MTF Healthcare Consumer Councils (HCC). This approach affords MTF Commanders the opportunity to address Senior Prime concerns while ensuring all PRIME categories receive appropriate representation on the MTF' s HCC.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the "richer of the Medicare or TRICARE Prime benefits," thus providing consistent health benefits at all Senior Prime sites. This policy may constrain the ability of the Region 6 plan to compete on benefits with other health plans in a highly competitive market, although the supplemental benefits offered by other plans may not be much richer than the Senior Prime benefits because Medicare capitation rates in this market are not high (as they are in San Diego).

Quality and Utilization Management System - The QM/UM teams are collaborative efforts among the staff responsible for QM and UM within the participating organizations - the Lead Agent, MTFs, and FHFS. The Quality Council of the Senior Health Plan Board oversees these activities. The Senior Prime

management team has relied on the existing QM and UM measurement systems wherever possible and has worked to establish consistent policies for the entire plan. The site's QM plan was first organized under the Medicare Section 1876 rules, but then was revised to comply with new Medicare+Choice rules. Utilization review is a contractual responsibility of FHFS, and FHFS Health Care Finders located at each MTF perform these functions.

Provider Networks - The San Antonio MTFs offer Senior Prime enrollees several choices of PCMs, including three clinics at Brooke AMC (family care, adult primary care network, and internal medicine) and two clinics at Wilford Hall MC (adult medicine and internal medicine). Most secondary and tertiary services also are provided in specialty clinics and inpatient units within the MTFs. In Texoma, Reynolds ACH has three PCM clinics (internal medicine and family practice 1 and 2) and Sheppard APB has two PCM clinics (family practice 1 and 2). Both MTFs offer some specialty care services, and enrollees requiring specialty care that the MTF does not provide are provided by network providers. Ft. Sill provides chiropractic care as a chiropractic study site.

For services not offered by the MTFs, FHFS establishes Senior Prime contracts with civilian providers, turning first to existing TRICARE Prime network providers, and then to new providers when necessary. Contracts also are established for Medicare-specific services, including skilled nursing facility care, home health care, durable medical equipment, and physical rehabilitation care. Provider recruitment has been difficult in the two Texoma market areas because of suspicion of managed care and unpleasant memories of slow payments from the military as TRICARE was being implemented. When enrollees need a service the enrolling MTF cannot provide, FHFS turns for referrals first to other MTFs in the area, then to Senior Prime network providers, and lastly to non-contracted providers.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - The Region 6 site was the second to be processed for Medicare certification, and it began service delivery in late 1998 (October for San Antonio and December for Texoma). The Medicare standards and processes changed during this time as HCFA established the Medicare+Choice rules and HCFA and DoD continued negotiations on program policy and design. When HCFA applied the new Medicare+Choice rules to the Senior Prime plans, this site revised its Medicare certification application and modified procedures to comply with the new rules.

Start-Up Activities - Education and training were key to successful start-up for the Senior Prime Program in Region 6. A professional marketing person at FHFS took the lead in preparing the marketing plan, which included advertising in local media and extensive series of orientation meetings at numerous locations within the San Antonio and Texoma service areas. Direct mail was used to reach as many people as possible, which required special approvals by TMA and HCFA. A presentation of the orientation meeting was given to the retiree associations before marketing began, and feedback was obtained on how to improve the briefing. They found they often walked a "fine line" between marketing and compliance with HCFA rules, as they aimed to provide information to potential enrollees. The approach in each location was tailored to the specific needs of the local beneficiary populations and MTFs.

A telemarketing company was hired to schedule appointments for the orientation meetings held during the 45 days before start of service delivery. Meetings were scheduled daily at a minimum, but as frequently as 3 times a day early in that period, decreasing to a less intense schedule toward the end. MTF staff who were speakers for the orientation meetings were trained on what to say and how to answer questions. FHFS sent staff to each MTF to perform this training, and they provided ongoing support to the MTFs during the start-up period. FHFS also brought in 50 to 70 temporary speakers for the meetings, and sent them to week-long training on Senior Prime and practice briefings. Some of these staff remained with F'HFS as permanent staff for continuing Senior Prime support services.

Enrollment - Enrollments at the two San Antonio MTFs quickly reached their planned enrollments of 5,000 per facility. Learning from the Madigan site's experience about the burden of large bulk enrollments, the Region 6 site staged enrollments for Brooke AMC and Wilford Hall MC at a rate of 1,700 per month for each facility. By contrast, enrollment demand at Reynolds ACH and Sheppard AFB was lower than their planned enrollments, and all eligible beneficiaries who applied at these MTFs were enrolled readily in the first month or two of service delivery. Enrollments at Reynolds ACH and Sheppard AFB continue to grow slowly. Reynolds ACH expects to reach its planned enrollment level, while achieving the enrollment level at Sheppard is questionable. Larger enrollments had been expected at Reynolds ACH because the MTF already had a Silver Care program that served seniors, but less than two-thirds of the Silver Care beneficiaries chose to join Senior Prime. Other reasons for low enrollment in Texoma are resistance to managed care in the community and concern about the short two-year life of the subvention demonstration. TRICARE Prime beneficiaries are aging in to TRICARE Senior Prime at a steady pace. Some Prime enrollees in the San Antonio area are reported to have changed their PCMs to the Senior Prime MTFs, so they will be eligible to join when they become Medicare eligible.

At the time of the RAND site visit, approximately 600 Senior Prime enrollees had not been able to attend the orientation sessions with some being either in a SNF or in custodial care. Currently, there is no mechanism for readily identifying those who might be in group homes or in assisted living arrangements.

Service **Delivery** – The processing of large numbers of new Senior Prime enrollees during the first few months of service delivery created a substantial workload burden for Brooke AMC and Wilford Hall MC, but the smaller numbers of enrollees at Reynolds ACH and Sheppard AFB were processed with less difficulty. Clinical staff at all the MTFs were pleased with the Senior Prime training they received, which allowed them to work effectively with the new enrollees. FHFS added new network providers or specialty services as demand documented the need to do so. Each MTF had its own approach to the intake of new Senior Prime enrollees and start of service delivery:

Brooke AMC hired additional staff into all its PCM clinics to manage the initial visits and follow-up care for Senior Prime enrollees. The internal medicine clinic filled up first because older patients tend to prefer internists as their primary physicians. Clinic staff worked with enrollees who were willing to change clinics, with the goal of achieving a better match between enrollees' needs and clinic capabilities. Internal medicine enrollees were contacted by telephone to educate them about Senior Prime processes and perform a health assessment. Depending on the assessment results, appointments were scheduled as immediate or within 7 to 30 days. The internal medicine clinic found that patient acuity was twice what they had expected to find. The adult primary care network and family care clinics both had "Meet Your PCM" activities for new enrollee intake. The clinics learned to do group intakes to ease the clinics' workload. Nursing staff played key roles in coordinating the early care for the new enrollees.

Wilford Hall MC held 30 orientation sessions for new Senior Prime enrollees, with personal invitations sent by mail. PCM clinic staff asked new enrollees to complete a questionnaire about health status and current medications, and they talked with them about rules and ways to use the system. A total of 3,400 enrollees attended the orientation sessions, many of them with companions. The clinics used nurse triage as enrollees came in for their initial PCM visits, to field questions and reduce physician workload. Staffing requirements in the PCM clinics were handled by re-engineering and reallocations rather than hiring additional personnel.

Start-up of service delivery for *Sheppard AFB* was relatively painless because the 800 new enrollees they processed was a small volume compared to their overall patient activity. New enrollees were given a Registered Nurse health screening using protocols developed by Internal Medicine providers. Patients were then scheduled for an Internal Medicine appointment, and appropriate laboratory, x-ray, and other diagnostic tests were collected prior to the appointment. This approach helped reduce physician workload. Although there was some initial confusion by enrollees, issues were easily resolved. Most of the questions were about physicians in the provider network outside the MTF. They allowed 60 days for

transition of specialty care services over to the provider network. In the early months, Senior Prime enrollees used referrals at about the same rate as Prime members.

Reynolds ACH also used nurse triage to help achieve smooth enrollments and intakes into service delivery. Impacts on the PCM clinics and specialty services were small because Senior Prime enrollees are a small fraction of total MTF enrollment. Both the family practice clinics and the internal medicine clinics had to work with enrollees to change specialty physicians. Recruiting network physicians was difficult because of negative attitudes toward managed care and a strong resistance to discounted reimbursement rates.

An issue shared by the four MTFs was some interruption in access for some enrollees with existing health care needs during the transition into Senior Prime from another Medicare health plan or fee-for-service providers. Some enrollees were using non-network providers, and had to switch to network providers, and others were using medications or other services (e.g., DME) that were at risk of being discontinued. The site acted immediately to remedy these problems as they were identified, and advised other demonstration sites to plan for early identification of these individuals during the application process to ensure continuity of care.

Quality and Utilization Management Processes – Before implementation of Senior Prime, this site had a strong TRICARE quality and utilization management process, which was extended to include the Senior Prime program. They have been focusing on defining a common set of metrics to monitor consistently across all the MTFs in the site. The monitoring experience that Reynolds ACH gained in the Silver Care program has contributed to their progress in building Senior Prime measures. The site is working to integrate the Senior Prime QM and UM monitoring with other DoD quality initiatives, such as the DoD/VA guidelines and related metrics and the study that FMAS is doing of Senior Prime measures. They also are coordinating with the state PRO, which has responsibility for external quality monitoring of Medicare health plans. At the time of the site visit, the site was still awaiting clarification on the QISMC standards being published by HCFA, and the leadership staff were beginning to work with the other sites to establish a demonstration-wide quality planning and monitoring activity.

To fulfill its UM and case management functions, FHFS has two UM nurses and one case manager each for Wilford Hall MC and Brooke AMC (six total in San Antonio). In the Texoma area, FHFS hired one UM nurse and one case manager each for Reynolds ACH and Sheppard AFB (four total). Criteria to qualify patients for case management , which are specified in the FHFS contract, include the DoD-mandated list of conditions, a chronic illness, the need for physical rehabilitation, and financially based case management (also called large or catastrophic case management). For all enrollees, including Senior Prime, the site wants to expand definitions for case management candidates to include certain clinical areas, and ultimately, to move to a disease management model. However, this requires significant change to the current FHFS contract.

Financial Performance – The Region 6 site participants expressed a strong concern about the financial impacts of the administrative overhead required to implement Senior Prime. In addition, increases in service activity for Senior Prime enrollees for pharmacy prescriptions and clinic visits translate into MTF costs. Despite doing well on the Level of Effort requirement, for example, Brooke AMC attributes to Senior Prime half of the $6 million loss that is anticipated for this year. Another contributor has been loss of third party reimbursements as beneficiaries enrolled in TRICARE Prime and Senior Prime. Reynolds ACH and Sheppard AFB noted that administrative costs do not vary much with the size of the facility, so these costs have proportionally larger impacts on the financial performance of smaller MTFs. Administrative costs, however, are quite small compared to service delivery costs.

This site has been modeling the financial impact of the payment system under which HCFA pays DoD for serving Senior Prime enrollees. They feel that this complicated system will not be feasible on a regional level, and they have highlighted that the cost thresholds for space-available care create undesirable incentives for the MTFs. Concern was expressed about whether the medical center would

see any funds for the Senior Prime services it provides. There has been no word from TMA about when or how cash will flow from TMA through the Services to the individual Lead Agent offices and MTFs.

Dynamics of the Local Medicare Managed Care Market - In San Antonio, the Senior Prime plan is a new entry into a competitive managed care market, including health plans with high rates of Medicare enrollments. Thus, many enrollees are accustomed to a managed care environment. It is worth noting that 10,OOOnew Senior Prime enrollees at Brooke AMC and Wilford Hall MC is a large number even in a highly penetrated market, and some of the enrollees previously had been members of other Medicare plans. The impacts on these plans as enrollees switch to Senior Prime will depend on how many enrollees they lose relative to the sizes of their total Medicare enrollments. A different situation exists in Texoma, where there was virtually no managed care before the introduction of TRICARE Prime, followed by Senior Prime. Thus, the key market dynamics are the reactions - both positive and negative - of the beneficiary and provider communities to Senior Prime as a managed care product.

EARLY LESSONS LEARNED BY THE SITE

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees' service needs.
   - Enrollee satisfaction is high due to improved access to care and TRICARE/Medicare benefits.
   - Personalized group orientations for potential enrollees are important techniques to educate them about Senior Prime.' Time should be allowed for one-on-one discussions of information and considerations about health care options.
   - Senior Prime orientation may be easier in markets with active managed care because beneficiaries tend to be familiar with managed care concepts and know what to look for when choosing a plan.
   - For an effective enrollment and intake process, start preparation early and anticipate staff resource requirements, which may be met by adding staff, re-engineering to shift staff assignments, or using flexible staffing strategies.
   - Training of PCM providers and front-line staff is important, both to establish trust as providers talk with beneficiaries during the orientation meetings and to help providers respond to questions from enrollees during the initial clinic visits following enrollment.
   - The existence of previous relationships with older beneficiaries who are impaneled at an MTF does not guarantee enrollment in Senior Prime because beneficiaries will consider available options and tradeoffs as they make health plan choices.
   - Education and assistance should be provided to non-enrollees, many of whom are concerned about their ability to continue to obtain care at the MTFs as space-available care declines, and will need to make transitions to community providers.
   - Structure the types and levels of PCM choices offered to allow flexibility in matching new enrollees to the best type of PCM providers for their health care needs and distributing enrollees evenly across PCM clinics.
   - Carry out an organized intake strategy for new Senior Prime enrollees that includes health screening and triage for PCM intakes, identification of existing conditions that require transition support, and instructions and support in using telephone appointment systems. Health screening methods should be appropriate for the older population. A variety of approaches can succeed, depending on the number of enrollees entering an MTF' s program
   - MTFs with large numbers of new enrollees should consider using staged enrollments at the PCM level to ensure that enrollees can be accommodated within available PCM clinic capacities.
   - Effective coordination of roles and activities between the MCS contractor and MTFs supports implementation because many of the contractor's activities take place in the MTFs or in

TRICARE Service Centers located in the MTFs or nearby, and MTF staff are directly involved in many of those activities.

- The MCS contractor incurs a large share of the administrative costs because of its substantial roles in marketing, enrollment, and enrollee services.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - It is important to identify potential enrollees with existing care requirements (DME, home health, etc.) to assist them to maintain needed services during transition to Senior Prime and to manage their care flexibly as they change to new specialty providers.
   - Case management should have a central role in Senior Prime, to achieve cost effective care for the multiple chronic conditions and other health problems of an older population. Provider education may be needed to ensure there is an understanding of this role.
   - When the MCS contractor performs the utilization review and case management functions, these activities need to be coordinated closely with the MTF clinical and support staff activities.
   - The establishment of an effective civilian provider network is more difficult in smaller markets with limited managed care because community providers typically have full practices and do not need new patients, and they tend to resist participating in managed care.
   - Providers at medical centers with a specialty focus and teaching programs will require training and support for functioning in a managed care environment that is directed by PCM providers.
   - Introduction of Senior Prime will increase service activity for specialty clinics as PCMs refer enrollees for follow-up care, although the impacts on clinics will differ by specialty and will occur at differing times following start-up.
   - VA hospitals and clinics are active participants in the service networks of many MTFs, and their absence from Senior Prime networks may be restricting access or continuity of care for some enrollees.
3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management.
   - Benchmark quality and access data for the dual eligible population is needed in CEIS, especially data and reports required to meet Medicare QISMC requirements.
   - Physician training on HCFA rules for documentation and coding is important to enhance data quality, which should be made available across sites.

IMPACTS ON BENEFICIARIES

We summarize here what we learned during our focus groups with the leaders of retiree associations, specialty providers, PCM physicians, and other front line clinical and support staff. These sessions generated information about the feedback that MTF staffs have been hearing from beneficiaries who received care at the medical center, as follows:

- Beneficiaries are pleased that Senior Prime helps fulfill the promise of health care for life.
- Senior Prime enrollees appear to have gained better access to care and continuity of services.
- Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and, which they fear will be taken away again. There also is some resistance in the Texoma market to the restrictions of managed care, which are characterized by some beneficiaries as a type of monopoly on service delivery.

- With reductions in space-available care, as a result of both TRICARE Prime and Senior Prime enrollments, access to MTF care for beneficiaries who do not join Senior Prime is declining.
- Senior Prime enrollees are reporting to their retiree association representatives that they are very satisfied with the care they were receiving.
- There are some concerns about the limited service area and enrollment for the demonstration and many would like to see Senior Prime opened up to all elderly retirees in the area as soon as possible.
- Some confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee. Although some of the initial confusion will abate, much probably will continue.
- Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions have lost the specialists who were providing both their specialty and primary care.
- There is concern about what will happen to Senior Prime enrollees when the demonstration ends, and what will be the impacts for those who dropped their Medicare supplemental insurance.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Impacts Common to All MTFs

- Introduction of Senior Prime has increased administrative and operating costs for the MTFs not only during the enrollment and start-up period, but also as a result of a shift in patient mix toward an older population who require more support services and utilize more health care services.
- The MTFs are concerned about their financial liability for Senior Prime enrollees, which they are not able to ascertain because the needed financial information is not yet available.
- Efforts are increasing to improve and coordinate data resources to support QM/UM activities.

Specific Impacts for the San Antonio MTFs

- The large volumes of new Senior Prime enrollments caused the PCM clinics to temporarily shift resources toward intakes of new enrollees, away from space available care.
- The specialty care culture has made it difficult for specialty providers to adjust to PCM-guided management and coordination of care for enrollees. Communication between primary care clinicians and specialists has improved, however, as patients are referred and treated.
- The specialty care needs of older populations are positive for the MTF's GME mission. Senior Prime enrollees may not be sufficient to support GME programs, however, and programs are at risk of losing the additional needed patient activity due to shrinkage in space-available care.

Specific Impacts for the Texoma MTFs

- Introduction of Senior Prime had limited effects on the daily delivery of health care services for the Texoma MTFs because the new enrollees were a small fraction of their total beneficiary populations.
- With smaller enrollments than planned, Senior Prime financial performance for these MTFs may be negative.
- Increases in utilization of health care services is lower than expected, including rates of referrals to specialty MTF and network providers.

Lead Agent

- Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and an increase in resource requirements. However, responsibilities for the Senior Prime program were assumed by existing staff resources.

- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.

FOUNDATION HEALTH FEDERAL SERVICES

- Workload has increased as FHFS has supported the new enrollee population.
- The FHFS enrollment system has been expanded and modified for Senior Prime enrollments.
- New demands are placed on FHFS staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- Contracting activities have increased as FHFS has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.
- FHFS has added staff in both its home office and Region 6 office to accommodate these new responsibilities and caseloads. Because FHFS is the TRICARE contractor for 3 subvention sites, they have achieved some efficiencies in their new Senior Prime functions.

Other Organizations

- Other Medicare health plans in the market are experiencing observable loss of enrollment, but it is not yet known what effects this may be having on the other health plans.

IMPLICATIONS AND ISSUES

The early experiences of the Region 6 site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

- Careful planning and execution of personalized marketing for eligible beneficiaries,
- Training of PCM providers, specialty physicians and front line staff on Senior Prime and care management techniques,
- Preparation for staged enrollments for MTFs with large numbers of new enrollees,
- Establishment of teams with staff from all participating entities working together to design and carry out the start-up and operations of the Senior Prime program.
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them
- Preparation for timely handling of grievances and appeals,
- Access to the data needed to monitor program activities and manage quality and utilization.

An important component of the operational success of Senior Prime in Region 6 has been the initiative by the Lead Agent office to coordinate implementation efforts across four MTFs and the MCS contractor. The early experiences of this site point toward strategies for broader implementation of Senior Prime across larger numbers of MTFs within a region, and they also highlight the complexity of running a regional plan and the importance of designing it to be manageable.

SUMMARY REPORT OF THE DOVER AIR FORCE BASE SITE VISIT
Site Visit Conducted on 12-14 April 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The Dover AFB site is the smallest of the six subvention demonstration sites. The organizations participating in its Senior Prime plan are the Office of the Lead Agent for TRICARE Region 1, the 436th Medical Group at Dover AFB, and Sierra Military Health Services, the Region 1 TRICARE managed care support (MCS) contractor. The Lead Agent office, which is defined as the Plan, is accountable to HCFA for the site's performance as a Medicare+Choice plan. The Dover MTF is the primary care provider for the site's Senior Prime enrollees. Sierra carries out various administrative functions for the Lead Agent, including the enrollment process, management of the network providers, and administrative services. The MTF and LA office are distinct entities. The LA office is located at Walter Reed AMC in Washington, DC, and the MTF is in Dover, Delaware, a small community in a rural area with little managed care penetration. Three Medicare health plans had been serving the market but discontinued their Medicare contracts at the end of 1998, and one new health plan began a Medicare contract effective January 1999. These plans serve about 6 percent of the local Medicare population.

The 436th Medical Group is an outpatient facility that provides primary care and limited specialty services. The facility has three PCM teams, and it also provides the primary care services of a minor surgical procedure unit, allergy and immunology, patient education, and a wellness center. Ancillary services of radiology, pharmacy, laboratory, and physical therapy also are provided, as well as the specialty outpatient services of obstetrics/gynecology, dental services and mental health services. All inpatient services for MTF patients are provided by civilian hospitals in the local communities. In particular, primary care physicians at Dover have medical staff privileges at Kent General Hospital in Dover, which allows them to continue to manage care for patients who are hospitalized there.

In addition to being the only site with just outpatient MTF services, the Dover AFB demonstration site is unique in several other ways. Although rural, it is located within a 2-hour drive from preeminent military medical facilities in the National Capital Area. It also is one of the sites for the FEHBP demonstration. In addition, TRICARE was being implemented in Region 1 in 1998 at the same time the Senior Prime demonstration was being designed and initiated. As a result, the two activities competed for resources in the Lead Agent's office, and the staff at the Lead Agent office and MTF were learning managed care for TRICARE Prime and Senior Prime simultaneously.

PROGRAM DESIGN

The Dover Senior Prime plan offers some useful insights regarding the feasibility of Senior Prime in small MTFs that do not provide specialty or inpatient services. Dover was the last site to be designated for the subvention demonstration, requiring it to work on an extremely tight schedule to begin service delivery by the January 1999 target date. The Region 1 Lead Agent office was managing the workload of TRICARE implementation at the time the Dover site was gearing up Senior Prime, and the Sierra MCS contract had only recently been implemented. Given these circumstances, the MTF took the lead for much of the early preparation, and the Lead Agent then moved more fully into it leadership role as the HCFA certification process was underway. During the development phase, Sierra brought in a consultant, Pacific Health Policy Group, who had Medicare managed care expertise and advised the Dover site on designing Senior Prime, getting certified, and preparing for enrollment and operations.

Plan Leadership - With the Office of the Lead Agent serving as the Senior Prime plan, policy and management leadership were established at the TRICARE region level. The Region 1 Lead Agent office lacked the resources to assign more than one full-time staff to Senior Prime. The staff members that dedicate the most time are the Senior Prime chief operating officer, who is full time, and the Senior Prime administrator, who spends 50 percent of her time on Senior Prime. The staff of the three

organizations (Lead Agent, Dover APB, and Sierra) work collaboratively to perform the functions required to operate a Medicare health plan, guided by the LA office.

Infrastructure - The Senior Prime plan was established as an extension of the Region 1 TRICARE Prime program, and already existing TRICARE Prime systems and processes were adapted to its requirements. A Senior Prime Plan Board of Directors was established that reports to the national TRICARE Board of Directors. The board membership consists of the three commanders (one from each Service) who alternate as the Region 1 Lead Agent and the commander of the Dover APB MTF, and a Sierra executive serves as a non-voting member. Reporting to this board is a Senior Prime Management Committee consisting of the current Lead Agent, Director of the LA Office, the Dover MTF commander, and the Sierra Vice President of Operations. A Quality Improvement Committee was established that reports to the management committee. This structure was designed to anticipate future expansion.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the "richer of the Medicare or TRICARE Prime benefits," thus providing consistent health benefits at all Senior Prime sites. This policy may place some financial stress on the Dover APB site, relative to the other sites, because Medicare capitation rates in this market are lower than they are in other subvention site markets, yet Dover covers the same scope of services as the other sites.

Quality and Utilization Management System - The QM/UM teams are collaborative efforts among the staff responsible for QM and UM within each organization - the Lead Agent, MTFs, and Sierra. The Quality Improvement Committee oversees and carries out these activities. Committees for utilization management, member services, and health services delivery report to this Quality Improvement Committee, as do subcommittees for medical records and peer review, credentialing, clinical indicators and studies, health promotion and disease management, and grievances and appeals. The LA office takes the lead in developing the QM plan, and the MTF and Sierra perform the QM functions within their respective service delivery activities. Utilization review is a contractual responsibility of Sierra, which drafts the plan's annual UM program plan and performs the utilization reviews and case management functions as specified in that plan, with oversight by the LA office and the utilization management committee.

Provider Networks - Three teams at the Dover 436th Medical Group provide primary care services. The galaxy team provides flight medicine services for active duty personnel only. The gold and blue teams are interdisciplinary teams with family practice, pediatrics, internal medicine, and obstetrics/gynecology. These two teams are the PCM providers for Senior Prime enrollees, and beneficiaries are enrolled to individual providers on these teams. Most specialty services and all inpatient services are provided by Senior Prime network providers located in the community or National Capital Area.

The site serves three distinct communities within its service area, and Sierra has established provider contracts in all these locations to ensure access for enrollees. Sierra turns to the TRICARE Prime network providers as the first sources of civilian care. Then it recruits new providers to contract for services that are not available in the Prime network, including Medicare-specific services such as skilled nursing facility care, home health care, durable medical equipment, and physical rehabilitation care. It has been difficult to recruit local community physicians for the network because of community resistance to managed care and previous bad experiences by physicians with the military health system, including low payment rates and delays in processing payments for services rendered.

Inpatient services are provided by local community hospitals and major military treatment facilities in the National Capital Area. Sierra has contracted with 3 community hospitals in the Dover service area. One of these is Kent General Hospital where the MTF physicians have clinical privileges as an external resource sharing agreement, which provides continuity of care for patients and reduces costs for network provider services. Although the National Capital Area military facilities are not part of the Dover site, some patients prefer to use them and Dover makes the referrals (and provides shuttle bus service). The Dover site also wanted to include the VA hospital in the Senior Prime network because it is a TRICARE

Prime network provider and many beneficiaries use the hospital. HCFA denied its request, unless Dover could document that its absence would compromise access to needed services, and Dover did not pursue the request further.

SENIOR PRIME IMPLEMENTATION

SUMMARY OF ACTIVITIES

Executing Medicare+Choice Contracts - The Dover AFB site was the last to be processed for Medicare certification, and it began service delivery in January 1999 as a Medicare+Choice plan. The new HCFA rules for Medicare+Choice were introduced as the site was being reviewed for Medicare certification. The HCFA site visit was conducted under the Medicare Section 1876 regulations, and the site had 10 days after the site visit to modify its application and procedures to comply with the new rules. Some of the uncertainty experienced by other sites, as negotiations between HCFA and DoD took place earlier in the year, may have been avoided by the Dover site because it was the last to be processed. The Dover site also was able to draw upon the documents and experiences of other sites as it designed its plan and prepared for certification. Given the concurrent schedule for TRICARE Prime and Senior Prime, every attempt was made by the Dover site to roll out similar policies for the two programs.

Start-Up Activities - The Senior Prime marketing and enrollment activities were compressed because of the lateness of the Dover certification and the time required for HCFA to approve marketing materials. Ads were placed in local newspapers in late October 1998, a month after the site visit, and the full marketing activities began in mid-November. Beneficiary briefings were held at an initial rate of 2 briefings per week, declining to 2 per month, and finally one per month. Most attendees of the briefings were MTF patients or former enrollees of the Medicare health plans that had left the market. The local retiree associations were very supportive of Senior Prime, and they placed notices in their newsletters, which had been reviewed by the site for accuracy. Some members also are supportive of the FEHBP option, recognizing that the overall capacity of the military health system is constrained by budget limitations and not able to support full service provision for Medicare-eligible DoD beneficiaries.

Staff and provider training preceded the start of marketing. MTF providers were brought into preparation for Senior Prime from the start, with training provided on Senior Prime benefits, how the program works and its special requirements. Knowledge has been refreshed through ongoing briefings and fact sheets. Providers also participated in the beneficiary orientations, which strengthened their knowledge and buy-in to the program. Sierra provided training for its staff on the functions they perform for Senior Prime, including training on how to interact with the older population, use of the CHCS appointment processes, beneficiary orientation meetings, and utilization management. A small group of staff were trained in the use of the Medicare Processing Center for enrollments.

Enrollment - The planned capacity for the Dover site represents the number of enrollees the site has the capacity to serve, but they expected to see limited demand for Senior Prime, resulting in smaller enrollments of 700 to 800 beneficiaries. Actual enrollments were less than 700 as of April 1999 and growing slowly. Indeed, the site reports that it has enrolled many of the beneficiaries who were using the MTF regularly but not many others who had been more episodic users. The open enrollment period has been extended until mid-July 1999. There is a limited supply of primary care providers in the Dover community so Senior Prime is attractive to eligible DoD beneficiaries. Yet demand has been constrained by the short life of the demonstration, travel distances to Dover for many in the service area who can obtain care locally, limited trust in the reliability of DoD policies, and resistance to managed care in the community. Age-ins of TRICARE Prime beneficiaries to Senior Prime also are occurring at slow rates.

Service Delivery – Nurse managers held initial evaluation meetings for new enrollees to record upcoming appointments with specialists, identify use of DME or medications, check for immunizations, and have enrollees complete the HEAR health screening forms. They also discussed preferred providers and checked the appropriateness of the PCM selected, and they gave information on appointments, advance directives, preventive services. All new enrollees then were scheduled for one-hour initial visits

with their PCMs, with the information from their evaluations ready for the PCM to review. A number of appointment times routinely are designated on the calendar for Senior Prime enrollees to ensure access to services, and follow-up appointments can be booked at the end of a current PCM visit. Inpatient services are provided by local community hospitals as well as other military facilities. Sierra handles referrals to network hospitals and specialty physicians, which includes pre-authorization requirements under the UM function. A nurse practitioner follows the patient through the specialty care process.

Quality and Utilization Management Processes – As the Dover site team prepared its Senior Prime QM/UM plan, it drew upon the plans already developed by other demonstration sites. Work groups were formed for different areas, and the Dover AFB clinic took the lead for much of the QM development work. Educational sessions were held on policies and procedures, including new ones established for the Medicare+Choice rules in November 1998. Sierra added an addendum to its existing TRICARE QM/UM plan for network providers to cover the Senior Prime requirements, and it plans to conduct a physician satisfaction survey. Sierra also serves as the interface with the PRO, as specified in the memorandum of understanding with the Lead Agent office. It is difficult to perform quality studies with the small number of enrollees at Dover (as well as most of the other sites), so much of the analyses will be aggregated for all sites. Region 1 has a comprehensive utilization management program that Sierra manages fully. They are changing "best practices" definitions as they learn new management methods. Efforts are underway to standardize QM activities across sites.

Financial Performance – The site estimates that it is losing money on every Senior Prime enrollee because of a combination of high administrative costs for a small population and low capitation payments that do not cover the average cost of health care for its enrollees. The amount of work required by Senior Prime also is detracting from other service delivery and support activities by the MTF. Given the estimated average loss per enrollee, the smaller enrollments are helping to mitigate financial losses.

Dynamics of the Local Medicare Managed Care Market – The Dover Senior Prime plan is virtually the only Medicare health plan in the site's market, and the departure of the three plans in late 1998 was independent of the entry of Senior Prime the following month. Some DoD beneficiaries who had been enrolled in one of those plans decided to switch to Senior Prime when it began operation. Thus, the dynamics in this market are the reactions of the community - both positive and negative - to Senior Prime as a managed care product, and the corollary impacts on the site's ability to recruit civilian providers to the Senior Prime network.

Early Lessons Learned by the Site

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees' service needs.
   - Senior Prime enrollee satisfaction, as reported to their retiree association representatives and to Dover MTF providers, is high due to improved access to care, TRICARE benefits, and responsive customer services.
   - Personalized group orientations for potential enrollees are important techniques to educate them about Senior Prime. Time should be allowed for one-on-one discussions of information and considerations about health care options.
   - Training of PCM providers and front-line staff is important, both to establish trust as the providers talk with beneficiaries during the orientation meetings and to help providers respond to questions from enrollees during initial clinic visits following enrollment.
   - Carry out an organized intake strategy for new Senior Prime enrollees that includes health screening and triage for PCM intakes, identification of existing conditions that require transition support, and instructions and support in using telephone appointment systems.
   - The enrollment procedures are cumbersome, requiring enrollment staff to enter data into several automated systems, and involving a 3 week delay until the site is notified about new enrollments, which leaves only a few days to send materials to enrollees and begin service delivery.

- Beneficiaries object to menu-based telephone appointment systems, especially those that are not operated locally by the MTF or TRICARE service center, leading to complaints about poor service and use of additional MTF staff time to assist them with appointments.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - Care to Senior Prime enrollees provided outside of the hospital needs to be coordinated carefully, especially when the site must rely heavily on network providers because the MTF does not provide a full range of services.
   - Case management should have a central role in Senior Prime, to achieve cost effective care for the multiple chronic conditions and other health problems of an older population. Provider education may be needed to ensure there is an understanding of this role.
   - When the MCS contractor performs the utilization review and case management functions, these activities need to be coordinated closely with the MTF clinical and support staff activities.
   - The establishment of an effective civilian provider network can be difficult in smaller markets with limited managed care because community providers typically have full practices and do not need new patients, and they tend to resist participating in managed care.
   - Historical problems with network provider payments during TRICARE startup are remembered by community physicians and contribute to later difficulties in recruiting them into new networks.
   - VA hospitals and clinics are active participants in the TRICARE service networks, and their absence from Senior Prime networks may be restricting access or continuity of care for some enrollees.
3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management. This site is using CHCS as its system of choice for Senior Prime data.
   - Benchmark quality and access data for the dual eligible population is needed in CEIS.
   - Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
   - Additional physician training is needed on HCFA rules for documentation and coding.
   - Centralized coordination to establish standard Senior Prime reports would assist monitoring and compliance activities.

IMPACTS ON BENEFICIARIES

We summarize here what we learned during our focus groups with the leaders of retiree associations, PCM physicians, and other front line clinical and support staff. These sessions generated information about the feedback from beneficiaries who received care at the clinic, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
- Senior Prime enrollees appear to have gained better access to care and continuity of services.
- Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration, which they fear will be taken away again. There also is some resistance in the market to the restrictions of managed care and distrust about this being only a partial effort to fulfill the DoD promise.
- There is concern by beneficiaries about what will happen to Senior Prime enrollees when the demonstration ends, and what will be the impacts for those who dropped their Medicare supplemental insurance.

SUMMARY REPORT OF THE COLORADO SPRINGS SITE VISIT
Site Visit Conducted on 19-21 April 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The four key participants in the Colorado Springs Senior Prime plan are the Office of the Lead Agent for the TRICARE Central Region, Evans Army Community Hospital at Ft. Carson, the 10th Medical Group at the USAF Academy, and TriWest Healthcare Alliance (the Central Region's TRICARE Managed Care Support (MCS) Contractor). The Lead Agent office, which is defined as the Plan, is accountable to HCFA for plan performance and compliance. Evans Army Community Hospital and the USAF's 10th Medical Group are the two main military treatment facilities participating in the plan, and serve as the primary providers of health care services to Senior Prime enrollees in this site. Peterson AFB clinic, which is affiliated with the 10th Medical Group, serves as PCM for USAF Academy enrollees who age into Senior Prime. TriWest Healthcare Alliance carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, and administrative services.

Of the over 134,43 1 DoD beneficiaries in the Colorado Springs market, about 10 percent are Medicare eligible and another 35 percent are retirees less than 65 years of age. The Colorado Springs area is a moderately penetrated managed care market, including two Medicare managed care plans that are serving 38.6 percent of the Medicare population. The Senior Prime plan represents new competition for these existing Medicare plans.

Evans Army Community Hospital is a 140-bed facility with a combined mission of readiness, active duty support, and integrated health care delivery. This facility, along with three troop medical clinics, supports a large deploying population based at Ft. Carson of approximately 15,000 active-duty troops in at least eight command units. There also are approximately 26,000 activeduty family members within Ft. Carson's catchment area. Evans ACH also is responsible for supporting the recently stood up 7" Infantry Division (Light) (an integrated AC/ARNG division), for medical proficiency training (MPT), and for AT site support of the RC/NG within a multi-state area. Approximately, 95 percent of the MTF's physician staff and 90 percent of its nursing staff are Professional Officer Fillers (PROFIS) assigned to deployable military units.

The USAF Academy has a smaller 40-bed facility that includes several outpatient clinics (e.g., internal medicine, family practice) and on the inpatient-side, a medical/surgical unit and a special care unit with 15 same-day surgical beds. In addition, the USAF has an outpatient clinic at Peterson Air Force Base. The USAF Academy hospital's mission is to support a young cadet population. Approximately 80 percent of the facility's medical staff also have mobility assignments.

PROGRAM DESIGN

The Colorado Springs site and market have unique features that are reflected in the design of this TRICARE Senior Prime plan. Recent deployments and routine training demands make this site particularly important for understanding interactions between Senior Prime and the readiness mission. To help initiate Senior Prime, TriWest brought in a consultant with Medicare managed care expertise, who advised the Lead Agent management team on HCFA rules and regulations, and assisted in preparing the application and for start-up of enrollment and operations.

Plan Leadership - With the establishment of the Lead Agent Office as the Senior Prime plan, the plan policy and management leadership were established at the TRICARE regional level. This approach would position the site for the possible expansion of Senior Prime within the TRICARE Central Region, through extension of the basic structure established for the demonstration. However, because the TRICARE Central Region is the largest of all the regions with a number of remote clinics, expansion of TSP region-wide may present some unique implementation challenges.

Infrastructure - The Colorado Springs Senior Prime plan was established within the TRICARE Central Region framework as an adaptation of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted where possible to its requirements. The Senior Prime Board of Directors for the TRICARE Central Region brings together the key organizational participants (Lead Agent, Evans Army Community Hospital, USAF Academy Hospital, and TriWest Healthcare Alliance) for coordination of policy and management. Reporting to this Board is the Senior Prime Management Team, consisting of a team coordinator and three full-time military personnel. In addition, two ad hoc members were added to cover financial management and information systems issues as needed. A Senior Prime Advisory Council has been established, with members from local military retiree associations, congressional offices, and others.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the "richer of the Medicare or TRICARE Prime benefits," thus providing consistent health benefits at all Senior Prime sites. Although this policy may constrain the ability of the Colorado Springs plan to compete on benefits with other health plans, the moderate capitation rates in this market may preclude plans from offering rich supplemental benefits.

Quality and Utilization Management System - The Senior Prime management team has adapted the Colorado Springs Region's well established TRICARE quality and utilization management programs for the Senior Prime plan. The. overall objective was to keep as similar as possible to the existing QM/UM system modifying existing processes and procedures only as necessary. The QM/UM team is a collaborative effort among the staff responsible for QM and UM within each organization - the Lead Agent, the two MTFs, and TriWest Healthcare Alliance. At this site, the contractor's role includes tracking of grievances. There is a formal QMAJM committee within the TRICARE structure that oversees these activities for both TRICARB Prime and Senior Prime.

Provider Network - The two military treatment facilities offer distinct options for Senior Prime enrollees. Evans ACH provides a mix of primary care and some specialty care services, and it has a Wellness Center and a disease management clinic for chronic medical conditions. The USAF Academy's hospital provides primary care services (internal medicine and family practice) as well as a limited number of specialty services. Fort Carson and the USAF Academy also share a number of services between them (e.g. urology, neurology), with Army and Air Force beneficiaries accustomed to receiving care at either location. The MTFs do not provide Medicarecovered services that are required primarily by an older population (e.g., SNF, hospice, home health, chiropractic services), or some specialty services.

When contracting with civilian Senior Prime providers, TriWest first recruits from among the existing TRICARE Prime network providers, and then contracts with new providers in the community for services that are not available from Prime network providers. Because Colorado Springs is an expanding business market with a growing population, civilian physicians are in high demand and have busy practices. They also dislike the military reimbursement rates. Therefore, it has been somewhat difficult to recruit physicians to the network or put resource sharing agreements into place to allow the MTFs needed flexibility to readily adjust staffing to accommodate recent deployments.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - The Colorado Springs site faced uncertainty periodically during the planning phase of the demonstration, as HCFA and DoD negotiated key decisions on program policy and design, and the new Medicare+Choice rules to the Senior Prime plans were introduced. As the site was preparing for the site visit, HCFA applied the new Medicare+Choice rules to Senior Prime. In response to the new rules, the Colorado Springs site revised its application, marketing, and enrollment materials immediately before the site visit. These "real time" events compressed the time available for

the site to prepare for program start-up activities. The site's Medicare consultant conducted two mock site visits for the site in preparation for the HCFA certification site visit.

Start-Up Activities - Education and training were an important part of starting up Senior Prime in Colorado Springs. The site trained the MTF staff first and then provided orientation for beneficiaries. Training meetings were held for all providers during the summer and fall 1998. TriWest trained the network providers and brought in DME businesses as part of the provider education process. TriWest also moved their experienced TRICARE beneficiary service representatives (BSRs) over to Senior Prime, and these BSRs then worked with and trained the temporary BSRs hired for the startup phase, including potential Senior Prime enrollees. The Advisory Council provided input on the implementation process. The site undertook extensive outreach to provide information and orientation for dual eligible beneficiaries about the Senior Prime plan and their Medicare coverage options, as described below. They received excellent media coverage, at least partly due to the district's Congressman, including TV coverage and articles in the local newspaper with interviews with the commanders and beneficiaries. Over 20 public service announcements were made on local radio and television stations. During a two-week period, beneficiary briefings were provided to over 3,300 attendees. Two briefings per site were given daily with representatives from the Lead Agent, the two military treatment facilities, and TriWest Healthcare Alliance in attendance at the briefings.

Enrollment - Enrollment at the Colorado Springs site was targeted to a January 1999 service delivery start date. The overall rate of Senior Prime enrollment has been slower than initially expected. The projected enrollment for the two facilities was 2,000 for Evans Army Community Hospital and 1,200 for the USAF Academy. As of April 1999, a total of 2,841 applications had been accepted by HCFA. Although the two facilities had been serving older beneficiaries in the past, a significant number of the Senior Prime enrollees were new patients. The site has acquired HCFA's McCoy System allowing them real-time access to HCFA's enrollment information. They felt that this system would help to resolve the time lag the site has experienced between HCFA approving enrollment and notification, due to MPC batch processing.

At the time of Senior Prime implementation, two local Medicare HMOs terminated services on December 31, 1998, leading to "dual enrollments" (Senior Prime plus another plan) by approximately 150 beneficiaries who were concerned about loss of coverage. They were denied enrollment because of the conflicting information entered into the processing system, and the site had to work individually with these cases to get them properly enrolled in Senior Prime.

In order to retain flexibility needed for their readiness mission, the site allowed enrollees to select the MTF but not their PCM. The USAF Academy's hospital enrolled into its internal medicine clinic, which quickly filled to capacity, so Peterson AFB clinic is taking their age-in enrollees. Evans ACH enrolled into its internal medicine clinic, using a staged enrollment with the goal of 500 enrollees per month over 4 months. There is strong consensus that the slower enrollment allowed more flexibility to gear up service delivery and manage enrollees' initial PCM visits, although it also tied up personnel for an extended period of time. At the time of the site visit, the MTF still had capacity for 374 enrollees. One surprise has been the large number of age-in enrollments, with Evans ACH reporting three times its expected rate of 30 per month. The facility expects total enrollments to exceed its enrollment target because of age-ins.

Service **Delivery** - The Colorado Springs site had the benefit of the earlier experiences of other sites, anticipating possible disruption of some services (e.g., DME) as enrollees switched from existing coverage to Senior Prime. They also were concerned about problems related to starting service delivery right after the New Year holiday. A cover letter was sent to each new enrollee in their membership packet asking them to contact the TriWest Service Center if they were currently undergoing any kind of treatment. In addition, representatives from local DME firms were included in provider education sessions, and they were asked to notify TriWest of any new Senior Prime enrollees they may be providing DME services, to facilitate coordination for these patients. Staff from all 4 organizations (2

MTFs, Lead Agent, and TriWest) were on-call during the holiday weekend to address any problems that may arise . They report that no service delivery problems arose.

The two MTFs had different approaches to orientation sessions for new enrollees. The USAF Academy hospital held hour and a half orientation sessions for the seniors and then scheduled many of them for a 20 minute "get acquainted" appointment with their PCM. Evans ACH held 5-6 hour orientation sessions for up to 50 beneficiaries at a time. To date, 953 enrollees have attended the sessions. Enrollees were introduced to the concept of managed care, recent changes in the Military Health System (MHS), screened for case management, asked to complete a Personal Wellness Profile (Senior) (PWP) health survey, and went over the self-care manual and what services were available at the MTF.

The intake processes enabled the two MTFs to identify many people with unmanaged health problems who needed follow-up care. Because the site is still in the early stages of service delivery, it is difficult to say whether the clinic activity will decrease after the initial visits. Follow-up services for enrollees with health problems are expected to place continuing demands on the clinics, thus reducing capacity for space-available care. Transitions to Senior Prime providers were reported to be made smoothly by many enrollees who had existing services for chronic conditions. TriWest Healthcare Alliance added new network providers or specialty services as demand documented the need.

TRICARE Region 11 has a centralized appointment center run by TriWest Healthcare Alliance, which serves all the TRICARE activities including Senior Prime. There also is a dedicated support telephone number that Senior Prime enrollees can call with questions about the program. The physician staff noted that having a centralized appointment center with the schedulers located outside of the MTFs has made it difficult for them maximize efficient use of their specialty clinics.

Deployment Effects. Recent deployments of Army and Air Force medical personnel have coincided with the start-up of the Senior Prime Program. The Air Force Academy saw the deployment of one of its four internists to Saudi Arabia, which slowed the hospital's ability to serve Senior Prime patients.

Deployments have had the most noticeable effects for Evans ACH. At the time of the RAND site visit, this MTF had lost approximately 25 of its medical personnel due to deployment of an element of the 10th Combat Support Hospital (CSH) to the Balkans. The loss of personnel was felt across both primary care and specialty care services. They expect deployment of additional elements of the 10th CSH to the Balkans in January 2000, and the facility's on-going training mission requires that PROFIS personnel be sent for 2-3 week periods to support field training exercises.

The facility identified resource sharing as one option for ensuring the necessary flexibility to adjust to personnel losses due to deployments. However, they note that the providers are difficult to recruit for resource sharing agreements and the short turnaround time necessary to put these into place don't make them amenable to meeting deployment demands.

Quality and Utilization Management Processes - As the Senior Prime staff are preparing to meet HCFA's QISMC quality requirements, they have adopted a data-driven approach to define priorities based on documented need for improvements in clinical processes or efficiency. Data limitations, especially ADS data, are hampering their ability to measure indicators readily. This site has made HEDIS the primary focus of their QM efforts although they note that HEDIS takes on different nuances when applied to the military health system They also recognize the importance of having a common set of indicators standardized across the sites. Reporting has been a challenge due to coding differences across the two Services and the information system support staff necessary to do analyses. They have consolidated the reporting mechanism at the Lead Agent level. Current efforts center on improving coordination between the MTFs and the network facilities.

Financial Performance - The financial impact due to administrative demands associated with implementing Senior Prime were expected to be fairly high at the MTF, Lead Agent, and managed care support contractor-levels. The Lead Agent and MTFs report, however, that no funds were allocated for start-up, and all the work was done by existing staff. They anticipate that administrative demands will remain relatively high. They also commented that they considered it problematic to use 1996 as the

baseline to calculate the LOE for the Colorado Springs site, because the number of beneficiaries age 65 or older being seen by the MTFs declined with the introduction of TRICARE Prime in April 1997. Network costs were expected to be high because a number of specialty services are being sent out to civilian providers. Yet the MTFs did not feel they had good visibility on what those costs may be due to the claims lag time. Senior Prime also is being introduced at a time of declining third party reimbursements due to reductions in space-available care. They plan to estimate the financial impact of Senior Prime on service delivery costs at mid-year. Obtaining a good estimate of the financial impact is expected to take some time, however, due to the enrollment ramp-up and claims lag. With recognition that LOE reconciliation credits and cash flow decisions are handled at the service level within DoD, concern was expressed about whether the military treatment facilities would see any cash for the Senior Prime services they provided.

Dynamics of the Local Medicare Managed Care Market -- The Senior Prime plan is a new entry into a moderately penetrated managed care market, and some of the Senior Prime enrollees had switched from other Medicare health plans. The loss of two local Medicare plans that terminated services on December 31, 1998, caused a great deal of concern for some beneficiaries who feared loss of coverage. In addition, several years ago this region experienced a disruption of its provider network due to concerns regarding timely payment, which the contractor had to rebuild. The site reported that one of the local Medicare HMOs had mentioned to retirees in the area the temporary nature of the demonstration, reminding them of the benefits the civilian HMOs could offer. This marketing effort was hypothesized to have resulted in some disenrollments from Senior Prime.

Early Lessons Learned by the Site

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees' service needs.
   - It is difficult to predict enrollment rates and patterns. A large number of enrollees signed up immediately for the Air Force Academy's facility, resulting in almost an immediate filling up of its internal medicine clinic's service capacity. At the same time, enrollment was slower at Evans ACH, and approximately 50 percent of its enrollees were new patients. This MTF experienced three times the aging in rate than had been originally predicted.
   - Enrollee satisfaction is high due to improved access to care and TRICARE benefits.
   - Through flexibility and expansion of clinic capacity, the MTFs have met TRICARE access standards for both Prime and Senior Prime enrollees.
   - Group orientations for new enrollees are a functional tool in educating them regarding providers, processes, and contact information; and may be a key in the future.
   - The Personal Wellness Profile health survey was an effective assessment/demand management tool for Evans ACH, allowing them to identify health needs and in particular, social and mental health support needs of the Senior Prime population. In contrast, the HEAR survey doesn't stand up as well in terms of assessing the health and wellness needs of an elderly population.
   - Providers and Beneficiary Service Representatives have important roles in working with space-available beneficiaries whose access to MTF care has decreased and with eligible beneficiaries who have not yet enrolled.
   - Given the high utilization of this population, the site recommends that enrollment capacity be based on access standards rather than simply counts.
2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - The transitional impact on space-available beneficiaries is not yet known.

- During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) and be flexible in managing their care.
- Care to Senior Prime enrollees provided outside of the hospital needs to be monitored carefully.
- Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
- Use of Resource Sharing assets should be permitted for Senior Prime.
- Extensive coordination between the MTF and network case management teams is required for continuity of patient care.
- The demand for services by this population was higher than expected. A number of enrollees had not been seen by a civilian provider for several years, and they had unmanaged medical conditions and preventive services also were lacking.
- Given apparent pent-up health care needs of new Senior Prime enrollees, adequate time needs to be allocated for the comprehensive physicals and follow-up visits required to establish stable care for them. To do so, additional resources, including ancillary support staff, would be beneficial to allow optimal use of clinic resources and space.
- Although the retiree associations would like to see the demonstration expanded, several leaders recognized the recent increase in deployments and wondered if it would in reality make it infeasible to expand the Senior Prime Program at this time.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management.
   - There is a need for a common set of indicators standardized across all of the sites.
   - System-generated reports should be available for utilization management for civilian providers (data currently is collected manually).
   - Benchmark quality and access data for the dual eligible population is needed in CEIS.
   - Small numbers of enrollees limits power for statistical inference on benchmarksand trends.
   - Additional physician training is needed on HCFA rules for documentation and coding. Additional coders are also required.
4. The site visit participants felt it was important to address the flexibility needed to accommodate the readiness mission, including deployments and on-going training missions. They expressed concern about the limited depth of the network. Resource sharing was not viewed as being a good option for this purpose because a treatment facility may require the physician's services quickly and for short period of time , yet it would take a longer time to negotiate agreements.

IMPACTS ON BENEFICIARIES

Focus groups with leaders of retiree associations, specialty physicians, PCM physicians, and other clinical and support staff were conducted. These sessions generated information about the feedback that they have been hearing from beneficiaries who received care at the two facilities, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.

- Many beneficiaries remain cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
- Senior Prime enrollees appear to have gained better access to care and continuity of services. The retiree representatives reported a high level of satisfaction among their members with the care they were receiving under the program.
- Substantial confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom). The phased-in enrollment process at Evans ACH led to some confusion about beneficiaries as to their actual start date for delivery of services.
- Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions are losing specialists who were providing both their specialty and primary care.
- Beneficiaries need continuing support and education as they make changes in enrollments and service providers; some of the initial confusion will abate, but much probably will continue.
- Beneficiaries were uncertain as to whether they should their Medicare supplemental insurance if they enrolled in TSP. At this site, the TSP team and retiree associations advised beneficiaries to keep their supplemental insurance at least for the first few months to see how things were going and then decide whether or not'they were satisfied with the program.
- Delays in start-up at this site effectively shortened the life of the demonstration and this may have contributed to the caution retirees used in signing up for the program.
- Beneficiaries required education on how managed care works and recent changes in the Military Health System.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Evans Army Community Hospital

- PCM clinics' service patterns have changed from provision of episodic care to active care management for their enrollees.
- Evans ACH use of the Personal Wellness Profile (Senior) (PWP) health survey proved to be an effective demand management tool over the HEAR survey. The PWP assessmentenabled this MTF's staff to identify early on individuals requiring immediate care and some social health needs of this population.
- The increase in service use by the seniors and requirement for follow-up care continues to place demands on clinics and has served to tie up some personnel for an extended period of time with staff having been pulled in from other clinics.
- The administrative burden of Senior Prime is high and the facility does not foresee it declining.
- The specialty care needs of older populations serves to maintain clinical skills and directly contributes to the readiness mission.
- Recent deployments, which have coincided with the start of service delivery, have posed a challenge in terms of being able to integrate this patient population into the facility's overall mission. Phased-in enrollment was critical for this MTF to achieve this.

USAF Academy Hospital—10th Medical Group

- The high service use of the enrollees was not anticipated, with many requiring comprehensive physicals and histories and follow-up visits. The loss of one internist due to a deployment affected the rate at which the USAF could see Senior Prime patients initially.

- It was a challenge to take Senior Prime patients on without additional resources. It would have been useful to have additional ancillary help such as nursing assistants, individuals to process these patients, to optimize clinic space, and to maintain efficient visit flow.
- Senior Prime has a high administrative burden, and the facility does not foresee it declining.
- The specialty care needs of the older population supports the readiness mission in terms of providing clinicians access to more complex patients to treat.
- Under Senior Prime, patient acuity has increased, relative to the young cadet population the MTF was previously seeing.

Lead Agent

- Leadership responsibility has increased, accompanied by redefinition of the Lead Agent functions and an increase in resource requirements. The Lead Agent Office has taken the primary role in implementing Senior Prime in this site, with the two military treatment facilities and the MCS contractor playing more of advisory roles and intersecting primarily at key decision points.
- The Lead Agent Office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- The Lead Agent has three full-time staff and one team coordinator dedicated to Senior Prime management. In addition, the Lead Agent has two ad hoc management team members on an as needed basis. The workload was not expected to decrease over time.

TriWest Healthcare Alliance

- Workload has increased as TriWest has supported the new enrollee population.
- The TriWest enrollment system has been expanded and modified for Senior Prime enrollments.
- New demands are placed on TriWest staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- Contracting activities have increased as TriWest has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.

Other Organizations

- Other Medicare health plans in the market are experiencing observable loss of enrollment, but the losses appear to have limited effects on the very large plans. Marketing to local military retirees by one health plan is a sign of concern about competitive pressure from Senior Prime.

IMPLICATIONS AND ISSUES

The early experiences of the Colorado Springs site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

- A robust provider network to support the needs of the senior population and to enable the military treatment facilities to retain the flexibility needed to meet their readiness mission,
- Training of specialty physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
- Responsive actions to identify and correct operational problems during enrollments,
- Ensuring access to case managers for all PCM clinics,
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
- Preparation for timely handling of grievances and appeals,
- Access to the data needed to monitor program activities and manage quality and utilization.

- Concerns about readiness and how TSP fits into the overall mission will need to be addressed.

The Colorado Springs site provides information on the Senior Prime experiences of two community-based hospitals that rely on their provider network for many specialty services, where two military Services are responsible for covering health care benefits to enrollees. The TRICARE Central Region is the largest of the TRICARE regions with 26 geographically dispersed clinics alone located within its TRICARE Prime service areas. The sheer size and distribution of military medical facilities within this region may pose certain challenges if TSP is expanded region-wide.

Importantly, recent deployments and routine training demands make the experience of this site particularly useful for understanding the potential effects of Senior Prime on the readiness mission, particularly for installations that may support a large deploying population. Most of the Army and Air Force medical personnel at this site are assigned to deployable military medical units. Deployments during Senior Prime enrollment and intakes, as well as subsequent service delivery to enrollees, place pressure on the program. These effects may occur for both primary and specialty care services, given that specialists often deploy in generalist positions. In addition, support of contingency operations can pose an unique challenge, when military medical units are tasked to support deploying maneuver units that are not part of the installation, as was the case for the 10th Combat Support Hospital at Fort Carson. Loss of MTF medical personnel due to a deployment, without an accompanying reduction in the troop population on post, creates staff shortages that could reduce access for Senior Prime enrollees. Given planned upcoming deployments and the fact that they are becoming increasingly a way of life for medical personnel, the issue of how to balance these competing demands warrants further examination.

SUMMARY REPORT OF THE KEESLER AFB SITE VISIT
Site Visit Conducted on 27-29 April 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The Senior, Prime plan for this site is named the Keesler TRICARE Senior Health Plan. The three key participants in this plan are the Office of the Lead Agent for TRICARE Region 4, the 81st Medical Group at Keesler AFB Medical Center, and Humana Military Healthcare Services, the Region 4 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, is accountable to HCFA for the site's performance as a Medicare+Choice plan. The Medical Center is the sole military treatment facility (MTF) participating in the plan, and it serves as the principal provider of health care services to its Senior Prime enrollees. Humana carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, utilization and case management, and administrative services.

Of the over 58,600 DoD beneficiaries in the Biloxi market, about 7,300 (12.5 percent) are Medicare eligible and another 19,500 (33.3 percent) are retirees and their dependents less than 65 years of age. The Biloxi area has virtually no managed care, although a small number of Medicare health plans serve zip codes in the Alabama portion of site's service area market. Therefore, Senior Prime is the only managed care plan in this area.

Keesler Medical Center is a teaching hospital that provides comprehensive inpatient and outpatient services and operates five residency programs and more than 80 other training programs. The medical center has a bed capacity of approximately 100 beds, with annual admissions of 5,500 patients and more than 419,000 outpatient visits per year. The MTF can provide many of the standard outpatient and inpatient acute care services for Senior Prime enrollees, but it does not provide some Medicare-covered services that are required primarily by an older population. Civilian providers in the Senior Health Plan network provide the services that are not available from the MTF.

PROGRAM DESIGN

The design of the Senior Prime plan at the Keesler site reflects the unique features of Keesler MC as a facility, the close relationship between the Lead Agent office and the medical center, and the relative absence of managed care in the Biloxi area. The commander of the medical center serves as the Region 4 Lead Agent, which allows close coordination of work between the two organizations. Staff from the Lead Agent office and medical center have worked closely together to organize and operate Senior Prime. Humana brought in Integrated Health Services as a consultant with private sector Medicare managed care expertise, who advised the site on Senior Prime design and preparing for enrollment and operations.

Plan Leadership - The Office of the Lead Agent was established as the Senior Prime plan, thus placing plan policy and management leadership at the TRICARE region level. Operationally, they began with the MTF taking the lead, but quickly switched to Lead Agent office leadership, consistent with its role as the Medicare plan. This approach was taken to position the region for the possible expansion of Senior Prime in the future, building upon the basic structure established for the demonstration. They view the Keesler program as a core resource that can support the introduction of Senior Prime at several other MTFs in Region 4.

Infrastructure - The Senior Prime plan was established within the Region 4 TRICARE framework as an extension of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted to its requirements, where appropriate. TRICARE began in Region 4 in 1996. The Keesler TRICARE Senior Health Plan Governing Board brings together the key organizational participants (Lead Agent, MTF, and Humana) for coordination of policy and management. This free-standing Board reports to the Region 4 Lead Agent.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the "richer of the Medicare or TRICARE Prime benefits," thus providing consistent health benefits at all Senior Prime sites. The Keesler plan appears to be able to maintain financial performance under these benefits, at least partially because of the high Medicare capitation rates for its service area. The competitiveness of these benefits is not an issue for this site because no other Medicare health plans are serving its market.

Quality and Utilization Management System - The Lead Agent office has oversight for the Senior Prime QM/UM activities, reporting to the Quality and Utilization Oversight Committee of the Governing Board. Quality activities, including data collection for monitoring, are delegated to the medical center staff for all services provided there, and to Humana for monitoring of network providers. TRICARE Region 4 purchases utilization management from Humana for both TRICARE Prime and Senior Prime. The site also has begun to introduce a disease management approach, with the intention to shift service patterns through coordinated management of individuals' health problems.

Provider Network - Three PCM clinics in the medical center serve Senior Prime enrollees, each of which has a mix of internal medicine and family practice providers to provide cross-coverage capability. The MTF also provides many specialty outpatient services, as well as inpatient care. For services the MTF does not provide, Humana first contracted with some of the existing TRICARE Prime network providers to participate in Senior Prime. Humana then contracted with new providers for services that are not available in the Prime network, including skilled nursing facility care, home health care, durable medical equipment, physical rehabilitation care, and chiropractic care. Recruitment of new providers worked well except for specialty physicians in the Biloxi area. The community providers resist managed care, do not like the low CMAC payment rates, and previously had bad experiences with slow DoD payments for services to military patients. As a result, many of the network specialty providers are located either east or west of the immediate Biloxi market area, and enrollees have complained about the distances they have to travel for these services. Senior Prime shares this problem with the TRICARE Prime program.

The site wanted to include the two local VA facilities and the Gulfport Naval Home as network providers. Keesler MC works closely with these facilities including sharing of services with the VA facilities, especially mental health services that the VA facilities provide. HCFA did not permit inclusion of the VA facilities because they are not Medicare-certified providers. The site did not request participation of the Gulfport Naval Home for two reasons. First, its skilled nursing unit is not Medicare-certified and, second, its primary care providers cannot be PCMs because all Senior Prime PCMs must be located at the MTF.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - During the time the site was processed for Medicare certification, the Medicare standards and processes changed as HCFA established the new rules for the Medicare+Choice program and HCFA and DoD continued negotiations on Senior Prime policy and design. The site revised its Medicare certification application when HCFA applied the new Medicare+Choice rules to Senior Prime, and it is in the process of modifying procedures to comply with these rules.

Start-Up Activities - The site's marketing and enrollment activities began on 1 October, following the HCFA site visit in August and subsequent certification. Service delivery started on 1 December. In this short time period, they undertook intense activities to achieve the targeted start date, which were challenged by a hurricane that hit the Gulf Coast at the end of September. The first step was education provided for clinical and management staff regarding Senior Prime and Medicare health plan regulations, in which the Command team was actively involved. About 30 briefings were held at the medical center over several weeks, preparing staff to handle questions from patients and be able to refer them to other

information sources. The beneficiary briefing was presented to the staff, which both educated them and informed them about what the beneficiaries would be hearing at their orientation sessions. Humana established dedicated staff for Senior Prime. A two-week training was conducted for the Humana staff, including 3 days on Medicare benefits, and a HCFA person was brought in to train them about Medicare. The Beneficiary Service Representatives (BSR) got additional special training.

Marketing began with advertising and communications activities. The advertising used included placement@ posters in public locations, newspaper ads in Sunday papers, ads in the base newspapers, press releases; and information booths in the commissary and BX on weekends. They did not use direct mail. They also worked with the retiree associations, inviting them to a meeting to inform them about the program. When marketing materials were available, they provided copies to the retiree associations to disseminate to their memberships. Retiree association representatives report that they reached over 3,000 members with Senior Prime information. Congressional staffers also were briefed to keep them up to date on the program The advertising and marketing activities continue at a maintenance level.

The beneficiary briefings began on 1 October, with over 2,200 beneficiaries attending the meetings. Attendance was limited to 200-250 at each meeting. They used an educational approach, discussing all options available to beneficiaries so they could make informed choices. Some time also was available for one-on-one discussions. They advised beneficiaries to keep their Medigap policies until the future of Senior Prime is more clear.. They believed this approach may have resulted in fewer enrollments, but it also should reduce disenrollment rates. They report positive feedback from beneficiaries on the marketing campaign.

Enrollment – At the time of the site visit, 2,699 beneficiaries had enrolled at the Keesler site, and another 85 were becoming effective in May. Although there are only 7,300 eligible beneficiaries in the Keesler site service area, their enrollment continues to grow steadily and they eventually expect to fill the targeted 3,100 slots. Learning from other sites about the impact of bulk enrollments on clinics' resources, the Keesler site staged its enrollments at a rate of 1,100 per month for the first two months (December and January), and then enrolled remaining enrollees as they applied. Humana processes enrollments at its headquarters in Louisville KY. This process entails use of 4 separate data systems, with separate data entry into each system. Humana dedicated two BSRs, one health care finder, and one patient care coordinator to Senior Prime. The BSRs are housed in the MTF instead of the TSC, which is 2 miles from the medical center.

They identified four groups of dual eligibles at Keesler who might enroll: a pool of 3,000 who regularly had used the MTF before, people who were using MTF specialists as their main providers, episodic users of primary care clinics and pharmacy, and users of only pharmacy services. When TRICARE Prime began, Keesler MC created a panel of 1,500 older beneficiaries assigned to PCMs as part of the medical center's GME mission, and many of the remaining dual eligibles received episodic care because of declining space-available care. The most common issues raised by beneficiaries were (1) what are the Senior Prime benefits, (2) a desire to use VA facilities, (3) desire for vision and hearing care, (4) concern about the short 2-year life of the demonstration, and (5) a need to retain their Medigap policies.

Service Delivery – Preparation for intake of new enrollees started even before HCFA had verified their enrollments, to prepare for continuation of DME and prescription medications and possible changes in specialty physicians in the transition to Senior Prime. They tested use of telephone follow-ups with beneficiaries who submitted an enrollment package to identify their current health status, services being used, and medications. They completed telephone screening with about 600 beneficiaries, but they experienced difficulties in contacting people and getting inadequate information by telephone, which led them to discontinue this approach. Medical center staff also worked with DME suppliers to make transitions for new enrollees. They found that these efforts helped reduce discontinuities in care.

Enrollee Education and Health Assessment for Seniors (EEHAS) sessions were held for new enrollees, which were attended by 80% of enrollees. Clinical staff led these sessions, at which they presented information on Senior Prime rules and covered benefits, performed health assessments, and provided

individual counseling for medical care needs. Enrollees were triaged to determine needs for PCM appointments, with the goal of scheduling appointments within one month for those who needed them. Many of the "panel" patients who had been seeing PCMs regularly did not need special initial visits. Those who had been using the facility episodically tended to have greater needs for care. The medical technicians and nurses continue to manage enrollees' care, answer questions, and help them move through the system. Staff in both PCM and specialty clinics have heard complaints from enrollees about problems with making appointments and their dislike of telephone consults or appointments and "800" numbers.

The specialty physicians report that the impacts of Senior Prime on their clinics vary widely depending on the specialty and the clinic's policy for handling referrals. For some clinics, patients just changed classifications when they joined Senior Prime. Other clinics have experienced a large influx of patients, with the timing of the referrals also varying by type of specialty. Some of the specialty physicians stated they liked the PCM role of triaging patients so the specialists can concentrate on the care they provide.

Quality and Utilization Management Processes – The Keesler site initiated the cross-site work on QM/UM metrics by suggesting this approach to the Lead Agent staff for the Region 6 site. The site staff saw that the complexity of the tasks merited joint efforts, and they understood that problems with completeness and quality of data from the DoD systems would make the work yet more difficult. With TMA agreement to this approach, the sites are working together to define measures and special studies, and TMA is organizing data collection with its contractors. The site still collects its own data to compare with these findings and to continue its work with the site's QM/UM clinical teams. Concerns were expressed about some of the Medicare QISMC standards, such as the enrollee's right to demand a service even if it is against medical judgment, and extension of the out-of-area allowance from 3 to 12 months. Due to problems with data accuracy and availability from the central systems, the site relies on local data generated in its CHCS and ADS systems for its monitoring activities.

The Keesler site already had several QM activities underway, which they expanded with the introduction of Senior Prime. These include a diabetes special study, monitoring of HEDIS-like measures, and self-reported health status information. Working groups have been established for several health conditions. They also held coding seminars for doctors to improve data on diagnostic and procedure codes.

Clinicians are very receptive to the metrics being generated. They understand the limits of the data, but they find the information useful to flag problems where they then drill down into charts to find the clinical stories.

Utilization management activities are being performed by both the medical center and Humana. They have determined that traditional UM pre-authorizations are becoming less useful, and they are moving to proactive management of care. In Humana's case management function, one ambulatory care case manager has been designated for Senior Prime case, and because this person is carrying a full caseload, they have added another person. Within the medical center, in-house clinical staff are doing case management for inpatient care. They also monitor both outpatient and inpatient care, and make arrangements for transition from outpatient to inpatient care for patients being admitted.

Financial Performance - Although the Keesler site has been following the interim payment reports, it has focused more on getting people enrolled and tracking performance, and as a result, they say the site is doing well operationally. The relatively high Medicare capitation rates in the Biloxi area are an advantage for the site. The payment rules are difficult to understand, which makes it hard for them to assess how the rules affect this site. The space-available LOE threshold for determining payments is not liked - it is a complex formula and hard to operationalize. They are concerned about the site's status relative to this threshold because their FY99 space-available visits for Medicare-eligible patients have declined substantially, and they do not see any actions they can take to manage it. They also want to receive the site's share of any Senior Prime cash flow from HCFA payments. Although these funds would not affect staffing levels, the resources would be fed into infrastructure. There also is a question regarding which fiscal year the funds are for, because the site cannot spend previous year funds. They

recommend that an easier method for calculating the LOE be developed, and the baseline year should be reconsidered for new plans, if Senior Prime goes systemwide.

Dynamics of the Local Medicare Managed Care Market - Because the Keesler TRICARE Senior Health Plan is the only Medicare plan serving the Biloxi market, it has no direct competition for enrollment of dual-eligible beneficiaries. The absence of managed care is accompanied by limited knowledge in the community about managed care as well as negative attitudes toward this model of care. Challenges created by these issues include the need for education for beneficiaries and the resistance of local specialty physicians to participating as network providers.

EARLY LESSONS LEARNED BY THE SITE

1. The following are observations by site visit participants regarding lessons learned about managing Senior Prime enrollments and accommodating enrollees' service needs.
   - The entire start-up process should be given adequate time to perform the tasks effectively.
   - Enrollee satisfaction is high due to improved access to care and access to TRICARE benefits.
   - Non-enrollees are concerned about their ability to continue to have access to the facility on a space-available basis and will require education as well.
   - Controlled personalized marketing and group orientations for new enrollees are important tools in educating beneficiaries regarding providers, processes, and contact information. They found it was important to limit the number of attendees at each meeting and allow time for one-on-one discussions in the sessions.
   - Continuing support for enrollees needs to be provided by the PCM clinics, including not only clinical counseling but also coaching on use of the system and listening to concerns.
   - The "informed choice" approach for beneficiary orientation to Senior Prime was constructive, and resulted in positive feedback from beneficiaries that they can trust what they are told.
   - If the site anticipates large enrollments, staged enrollment should be used to avoid undue stress on clinic capacities.
   - Local retiree associations need to be involved in developing the program, but bringing them in too soon may violate Medicare rules on enrollment activities.
   - The enrollment processing system is vulnerable to enrollment errors or delays because data from applications must be entered separately into multiple systems, and such a system could cause substantial problems if Senior Prime is implemented more broadly.
2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) to achieve a smooth transition into Senior Prime with minimal service disruption. Pre-enrollment telephone screening for existing service needs, however, was found to be only marginally useful for gathering this information.
   - Recruitment of network specialty physicians is difficult in areas with little managed care, and memories of low DoD rates and slow payments during the early days of TRICARE make the task harder. These memories remained even after many of the problems were resolved.
   - Care to Senior Prime enrollees provided outside of the hospital needs to be coordinated carefully to support exchange of charts and other information between military and network providers, and to ensure continuity of care as the patient moves between the two sectors.
   - Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.

- Strong communication and partnering relationships among the MTF, Lead Agent, and MCS contractor are essential to effective management of Medicare compliance issues.
- The utilization and case management activities should be supported by staff education, and strategies should be explored to create incentives for providers to want to use these practices. The MTF and MCS contractor activities should be coordinated to protect continuity of patient care.
- An important aspect of the Medicare appeals and grievances requirements is careful documentation of complaints received from enrollees and the site's responses to those complaints, both for the customer service aspect of care and for identification of potential problems for QM or UM monitoring and action.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management. As a result, this site has chosen to use its own local data systems (CHCS and others) for its monitoring activities, and not rely on CEIS.
   - Benchmark quality and access data for the dual eligible population is needed in CEIS.
   - Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
   - Additional physician training is needed on HCFA rules for documentation and coding.

IMPACTS ON BENEFICIARIES

We summarize here what we learned during our focus groups with the leaders of retiree associations, PCM physicians, specialty providers, and other front line clinical and support staff. These sessions generated information about the feedback that these groups have been getting from beneficiaries who received care at the medical center, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
- Senior Prime enrollees appear to have gained better access to care and coordination of services.
- Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
- Enrollees' reactions may differ by how much they used the MTF before Senior Prime. Staff report that those who had been using the MTF regularly (the panel) tend to be disgruntled because Senior Prime is managed care, and those who were denied care before are pleased to be using the MTF.
- Retiree association representatives report that Senior Prime enrollees are saying they are very satisfied with the clinical care and customer service they are receiving at the medical center.
- Some confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee. In particular, many enrollees dislike the telephone appointment system and do not understand how to use it correctly. Beneficiaries need continuing support and education; some of the initial confusion will abate, but much probably will continue.
- The space-available beneficiaries have lost access to primary care clinics, but it is not yet clear how much of that was due to intake activity during the early Senior Prime enrollment period. Some specialty clinics still are serving space-available care patients.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

81st Medical Group at Keesler AFB Medical Center

- Introduction of Senior Prime has had substantial effects in the primary care clinics and some of the specialty clinics of the MTF. Administrative costs to start the program have been high, and operating costs may be increasing with a shift in patient mix toward an older population.
- Effects of Senior Prime vary by specialty clinic, but the program does increase caseloads for many specialty services and it may contribute to increased ER use by space-available patients.
- The specialty care needs of older populations are positive for the MTF's training/GME mission.
- Senior Prime supports the readiness mission by helping providers maintain skills in surgical procedures, ICU procedures, and critical care transports (there are 20 C-CAT teams at Keesler). Specialty providers report that the ICU would be under-utilized without Senior Prime.
- Senior Prime is competing with the readiness mission in other ways because managed care requires tremendous coordination, and deployments and rotations of physicians make it hard to fulfill the clinical obligations to Senior Prime patients.
- Senior Prime is reinforcing the MTF's activities to strengthen its overall QM/UM activities.
- The MTF has lost revenues from Medigap insurers for Senior Prime enrollees.
- If this program is to be expanded to all MTFs, each MTF would require a dedicated staff for Senior Prime, given the administrative burden.

Lead Agent

- Leadership responsibility has increased, accompanied by redefinition of the Lead Agent functions and increased demand on available resources. With these demands, coupled with existing staff shortages, the Lead Agent office staff reported substantial workloads as Senior Prime was implemented.
- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- If this program is expanded to all MTF's in the region, the Lead Agent office indicates it is considering the need to establish satellite offices at the participating MTFs.

HUMANA MILITARY HEALTH SERVICES

- New workload demands are placed on Hurnana staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- The Humana enrollment system has been expanded and modified for Senior Prime enrollments, and staffing has been increased to support Senior Prime enrollees. The TRICARE Service Center has been expanded to accommodate these increased activities.
- Contracting activities have increased as Humana has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.

Other Organizations

- Because the VA facilities in the Keesler site service area were denied participation as Senior Prime network providers, and these facilities share services extensively with the medical center, there may be discontinuities in care for beneficiaries who have been using both types of facilities.
- The Gulfport Naval Home cannot participate as a primary care provider in Senior Prime, thus restricting access to Senior Prime for its residents and potentially disrupting continuity of care when the residents need to use the medical center on a space-available basis.

IMPLICATIONS AND ISSUES

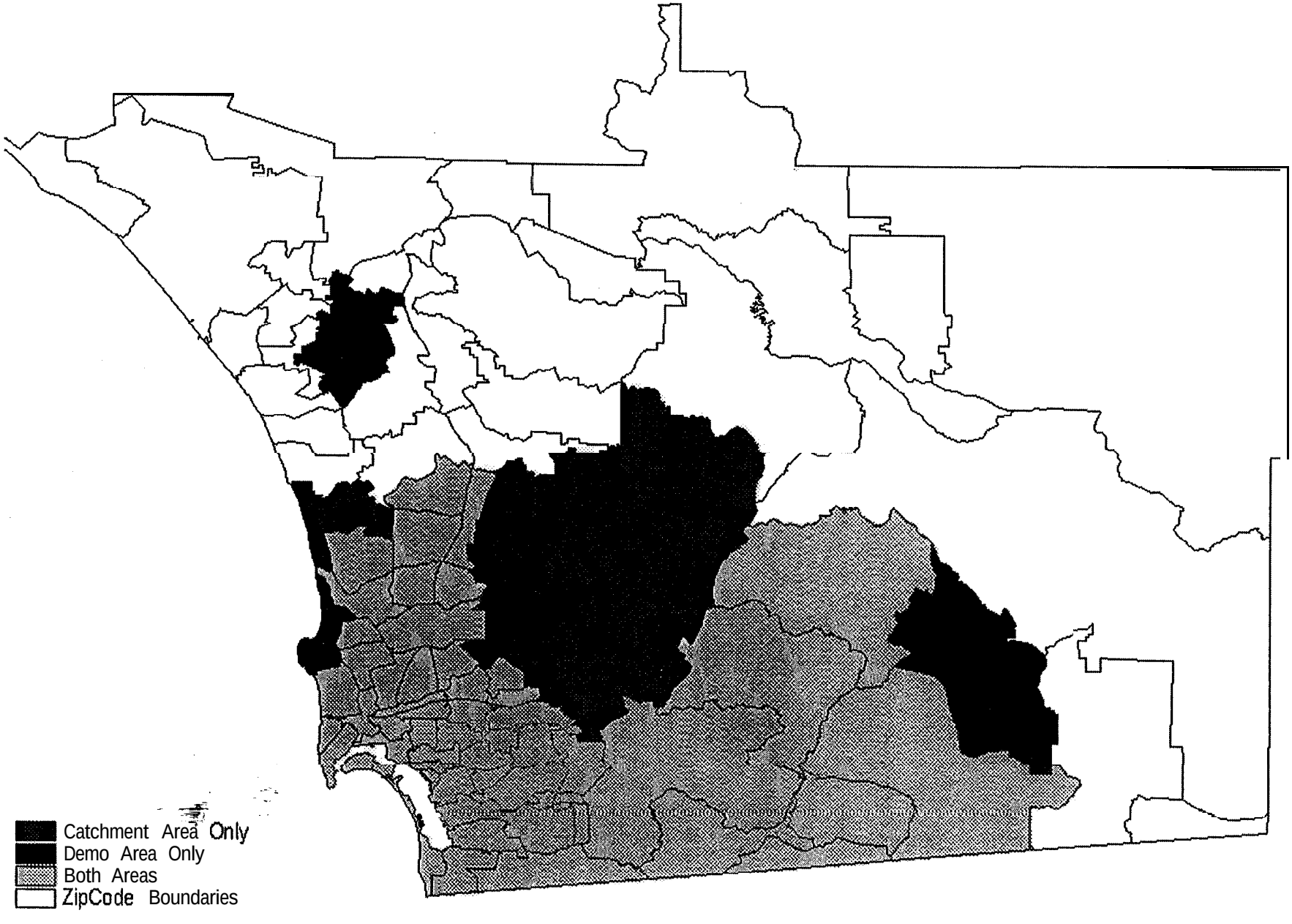
The early experiences of the Keesler AFB site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

- Controlled personalized marketing to build confidence on the part of enrollees,
- Establishing a provider network in the community that offers ready access to nearby providers,
- Training of physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
- Close working relationships with the HCFA regional offices throughout the certification, start-up, and operational phases of Senior Prime operation.
- Coordination of utilization and case management activities by the MTF and MCS contractor,
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
- Preparation for timely handling of grievances and appeals,
- Access to the data needed to monitor program activities and manage quality and utilization.

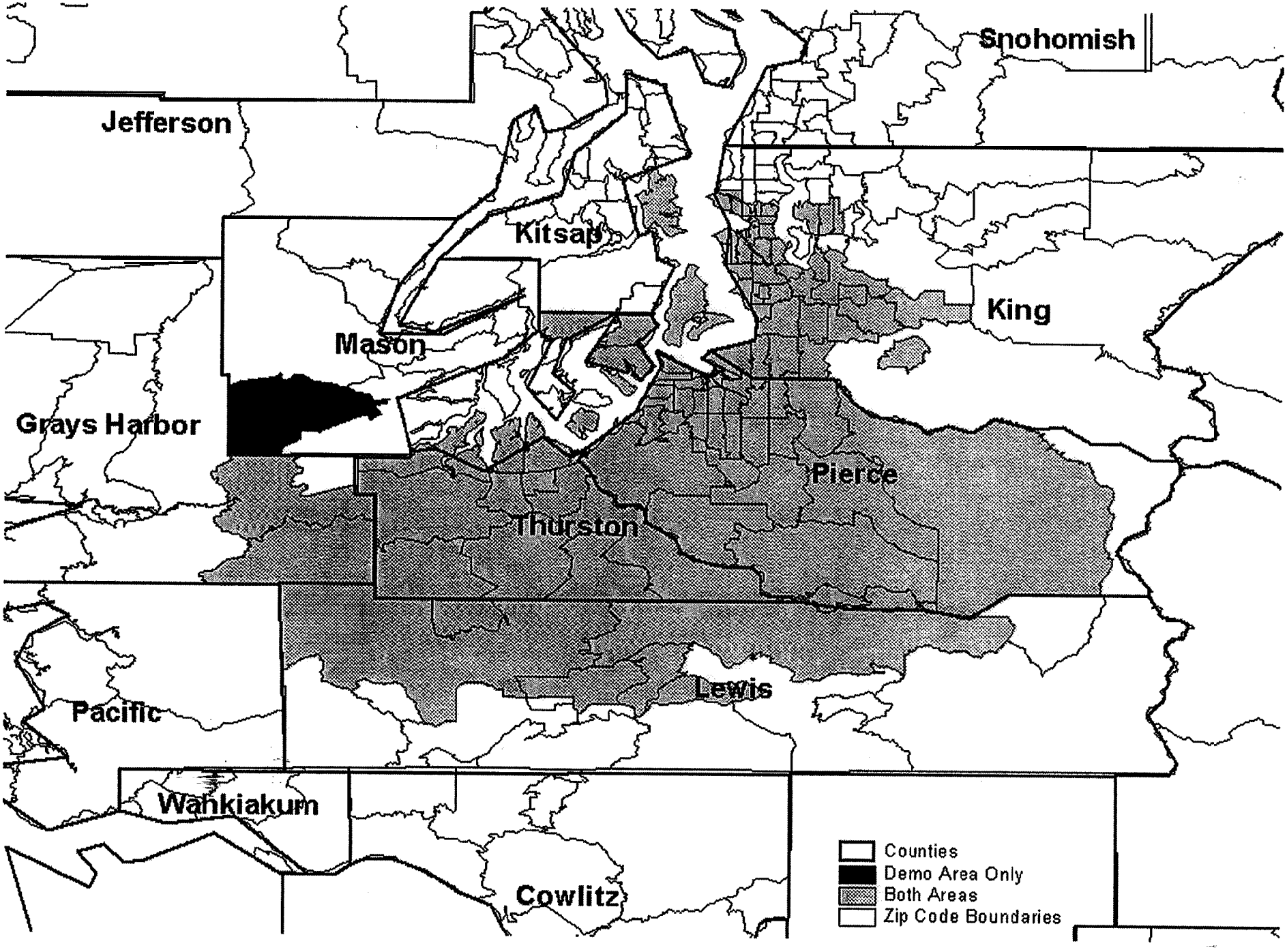
The Command team at the Keesler site provided feedback based on their experiences thus far with Senior Prime, highlighting that if DoD really wants to serve the older population, then it is necessary to put the resources behind it to do it correctly. The following major issues were identified: (1) substantial staff resource requirements for Senior Prime, along with rotations of military personnel that hamper program continuity, where it is especially important to retain Medicare expertise; (2) difficulties in achieving an adequate provider network in the Biloxi market to provide geographically reachable services; and (3) desire to receive its share of any funds paid by HCFA for Senior Prime enrollees.

Appendix D
Demonstration Sites

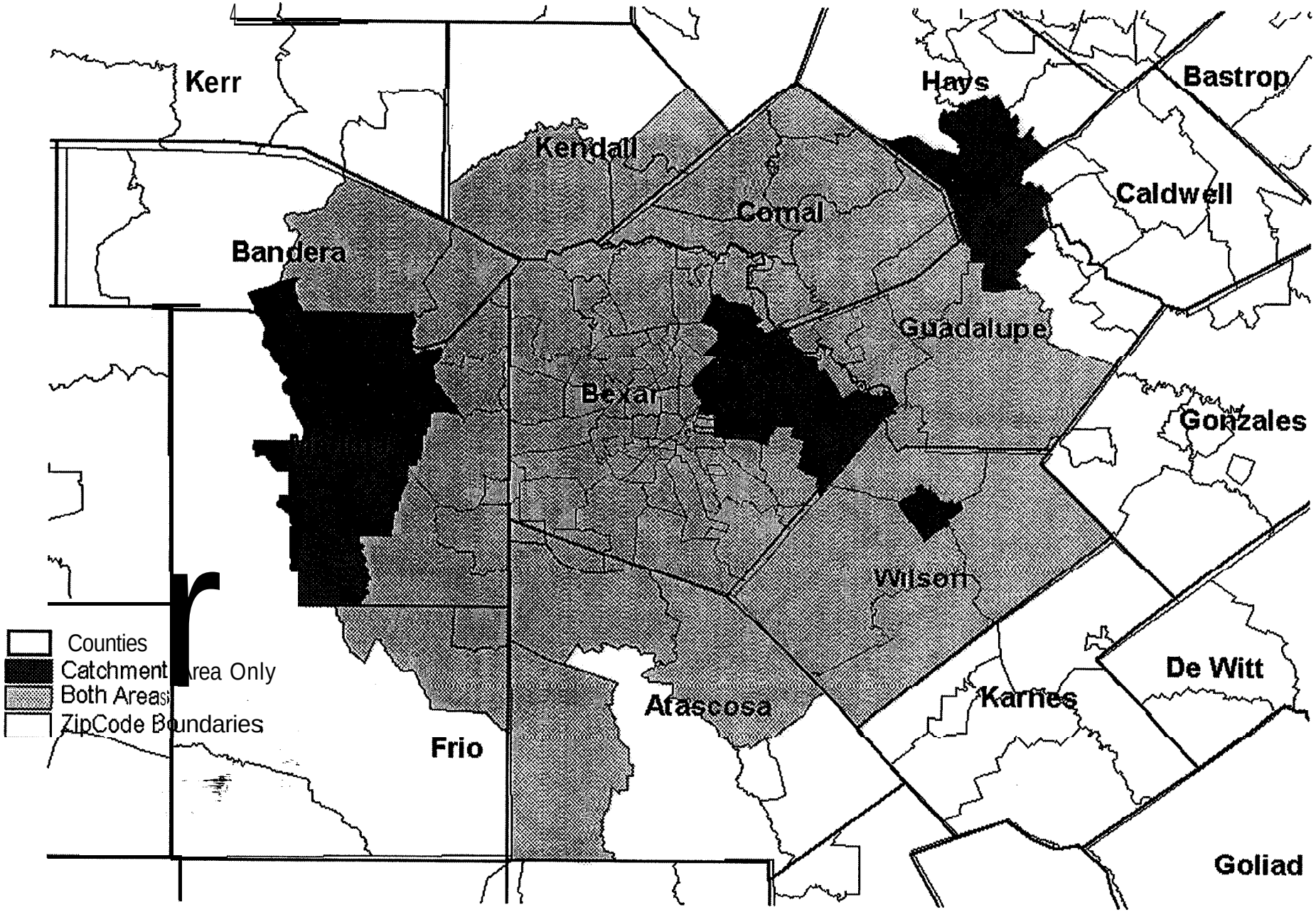
SAN DIEGO AREA



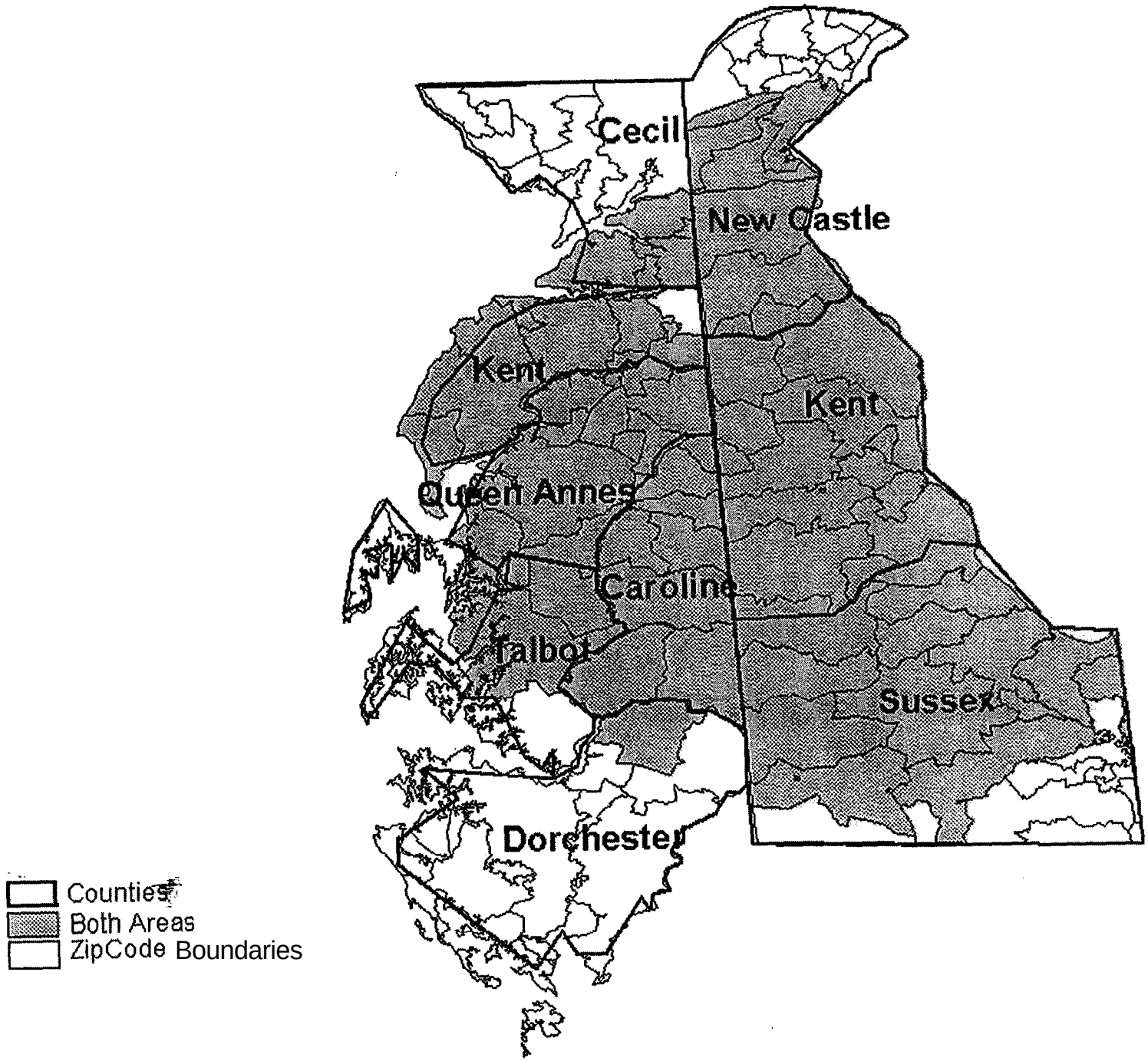
MADIGAN AREA



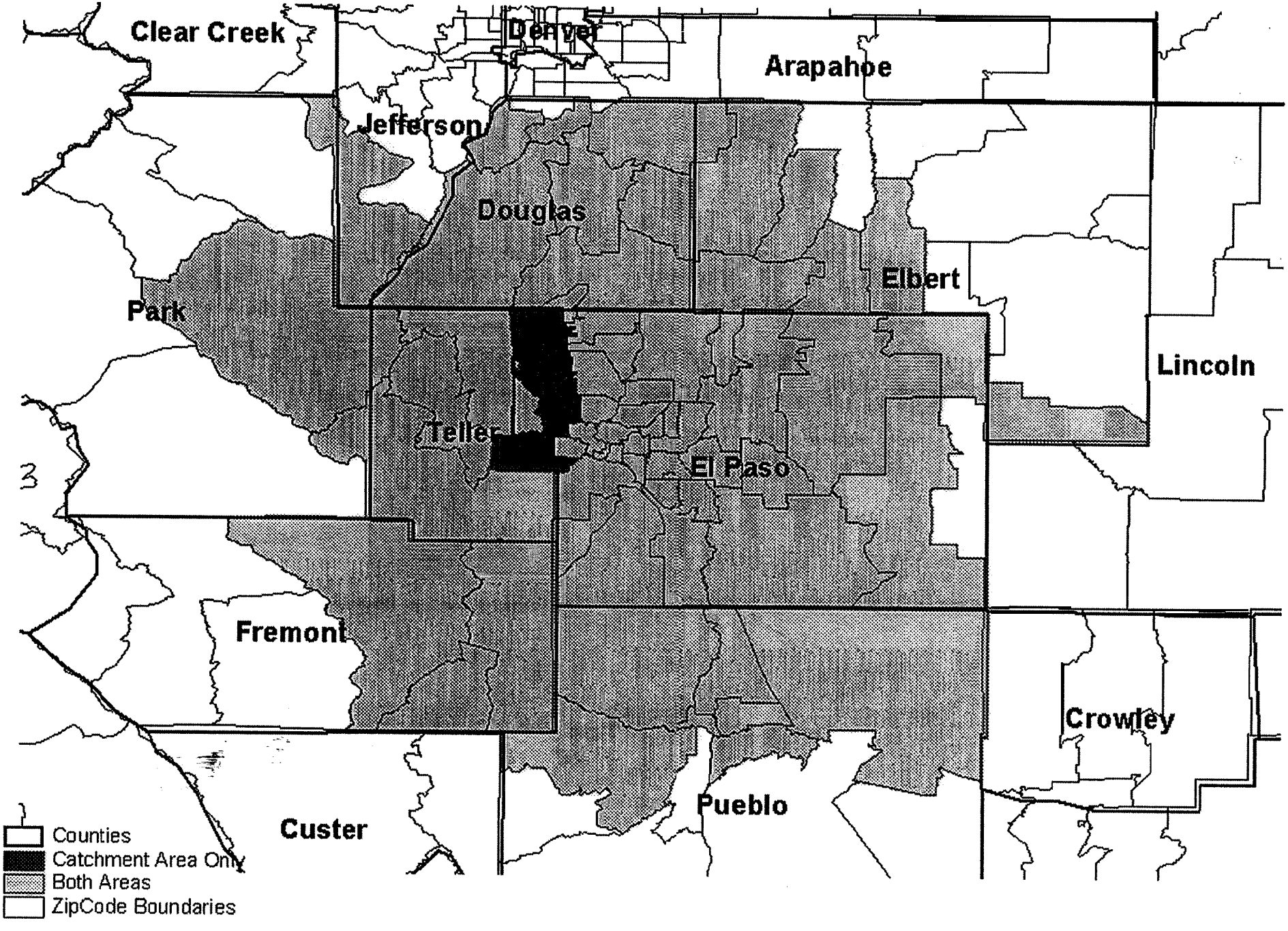
SAN ANTONIO AREA



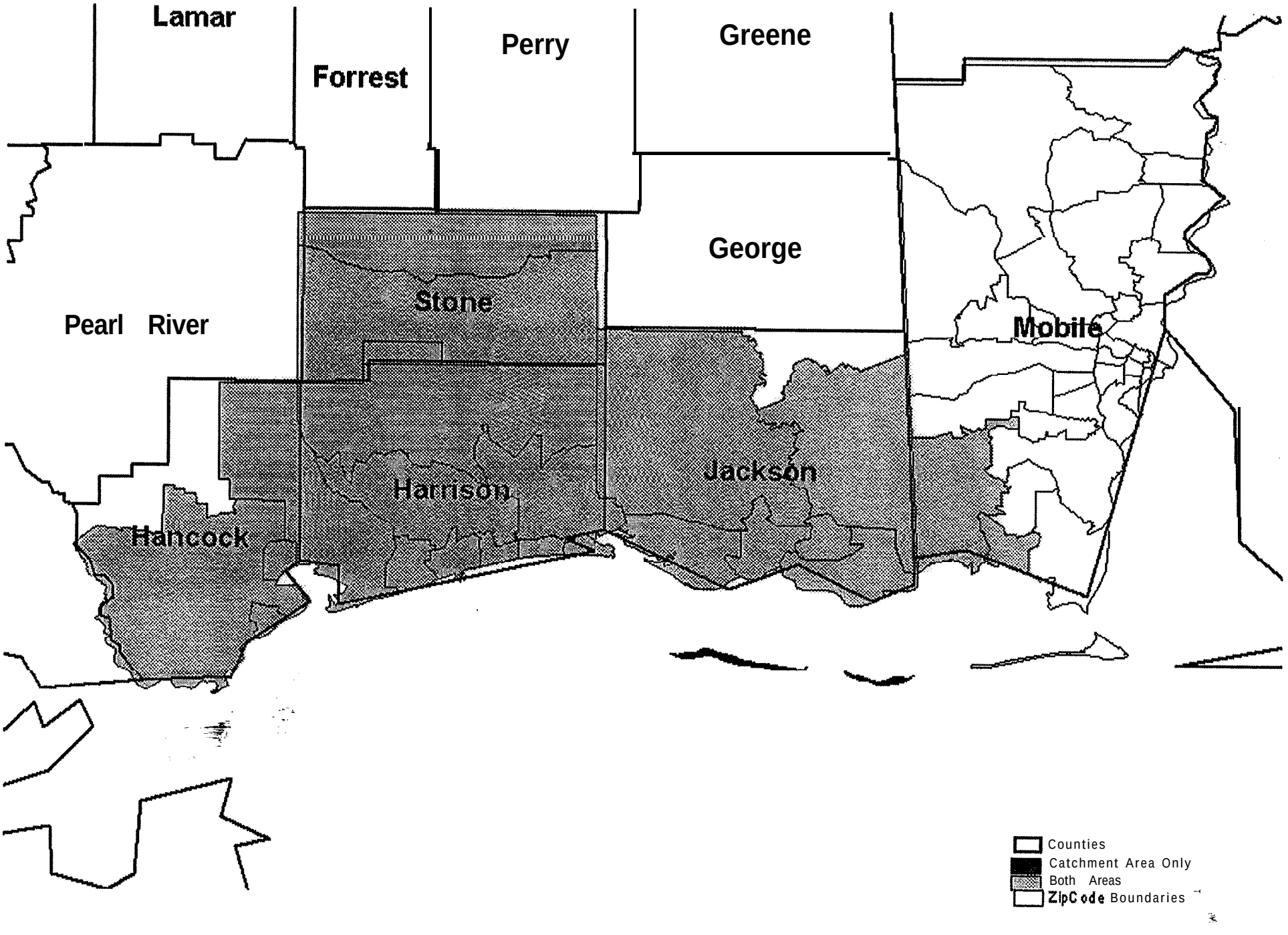
DOVER AREA


Cecil
New Castle
Kent
Kent
Queen Annes
Caroline
Talbot
Sussex
Dorchester
Counties
Both Areas
ZipCode Boundaries

COLORADO SPRINGS AREA



KEESLER AREA



REYNOLDS SHEPPARD AREA